REPORT BY THE

AUDITOR GENERAL

OF CALIFORNIA

THE DEPARTMENT OF INSURANCE NEEDS TO MAKE SIGNIFICANT IMPROVEMENTS IN ITS REGULATORY PRACTICES AIMED AT CONTROLLING INSURERS' INSOLVENCIES

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The Department of Insurance Needs To Make Significant Improvements in Its Regulatory Practices Aimed at Controlling Insurers' Insolvencies

P-029, June 1992

Office of the Auditor General
California

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June 25, 1992 P-029

Honorable Robert J. Campbell, Chairman
Members, Joint Legislative Audit Committee
State Capitol, Room 2163
Sacramento, California 95814

Dear Mr. Chairman and Members:

The Office of the Auditor General presents its report concerning the Department of Insurance's need to make significant improvements in its regulatory practices aimed at controlling insurers' insolvencies.

Respectfully submitted,

KURT R. SJOBERG
Auditor General (acting)

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The Department of Insurance (department) is responsible for protecting policyholders, beneficiaries, and other members of the public from losses arising from insurance company insolvencies. The department provides this protection by screening would-be entrants into the field of insurance, analyzing insurers' financial statements, conducting field examinations, regulating insurance rates, investigating consumer complaints, and enforcing compliance with the California Insurance Code. However, during our review of the department, we noted the following conditions:

- From 1974 through 1991, the department did not always take prompt and decisive action when it detected conditions hazardous to insurers' solvency. These conditions were insurers' questionable investments, improper reinsurance arrangements, improper affiliate transactions, loss reserve deficiencies, poor underwriting, poor use of managing general agents, and agents' high balances;
- Communication among the nation's state regulators is poor and ineffective;
- Coordination between the department and national agencies is ineffective; and
- The costs of California's guarantee association for property and casualty insolvencies are increasing.

Background

One of the department's responsibilities is to protect consumers from losing money because of the insolvency of insurance companies licensed to do business in California. To protect California consumers, the department regulates nearly 1,900 insurers and approximately 300,000 individuals licensed to conduct insurance business in California. These companies collect nearly $50 billion in premiums yearly from their policyholders.

The Department Did Not Always Take Prompt and Decisive Action After It Had Discovered Problems Leading to Insurers' Insolvencies

During our review of a sample of 14 insurers that became insolvent between 1985 and 1991, we found that, in general, the department identified the problems leading to the insolvencies. The problems we identified were questionable investments, improper reinsurance, improper affiliate transactions, loss reserve deficiencies, poor underwriting, poor use of managing general agents, and agents' high balances. However, the department did not always take prompt and decisive action after it detected these problems. Instead of taking effective regulatory action to correct them and to mitigate the harm to policyholders, the department relied upon informal and time-consuming discussions that failed to yield any appreciable results.

Delaying prompt and effective regulatory action can increase the costs of insurers' insolvencies. First, if an insurer is allowed to continue writing new business during the period in which the department tries to informally discuss corrective action, then more policyholders will be adversely affected if the insurer fails. Second, the financial condition of the problem insurer may continue to deteriorate during this interim period. For example, in cases such as Pacific Standard, the delay allowed the parent company of the insurer to remove valuable assets from the company. The financial consequence of such an action is ultimately an increase in the financial cost of the insurer's insolvency. Third, the costs of the insolvencies are passed on to the policyholders of healthy companies in the form of higher insurance rates. Another effect of insolvencies is that policyholders whose policies are not covered by a guarantee fund can lose their life savings.

California established the California Insurance Guarantee Association (CIGA) and the California Life Insurance Guarantee Association (CLIGA) for the purpose of paying the covered claims of member property and casualty and life insurers who became involvent.

The Department Should Improve Its Coordination With the Regulators of Other States and National Agencies

During our review, we found that communication among state regulators is poor and ineffective. In general, state regulators were reluctant to share information about financially troubled insurers. Furthermore, when other states do share information, it is often so outdated that it is of little value. According to a United States General Accounting Office survey, only 15 state regulators would fully share information with other states and provide regular updates on a financially troubled insurer. Some state regulators said they were concerned that if other states learned about a problem insurer, they might suspend the insurer's license, thus, making the situation public and increasing the chances of insolvency.

We also found that the California department failed to diligently pursue information that could have shed more light on the financial problems leading to the insolvencies of five insurers we examined that were incorporated in other states. In most instances, the California department opted to wait and let the domiciliary state take action rather than take action itself. A domiciliary state is the state in which an insurer is incorporated or organized.

In addition, as part of its regulatory responsibilities, the department screens entrants applying to transact insurance business in California. This screening includes a background investigation of all officers, directors, and major stockholders of an insurer when the insurer applies for a new or amended certificate authorizing them to transact business in California. In conducting these background investigations, the department contacts other agencies such as the Securities and Exchange Commission (SEC) and the National Association of Insurance Commissioners (NAIC) and

requests information on whether these individuals have had any regulatory or disciplinary action taken against them.

We found that the coordination between the department and national agencies is ineffective because the department's system of contacting these agencies has several flaws. For instance, under the department's current screening process, once it has been confirmed that an individual has had no previous adverse regulatory actions directed at him or her, the department would never again inquire about that individual unless he or she were to apply for another new or amended certificate. In fact, when we ran a list of the officers and directors affiliated with our sample of failed insurers against the records maintained by the SEC and the NAIC, we found 14 instances where some kind of disciplinary action had taken place concerning individuals with similar names after the department's granting of a new or amended certificate. Furthermore, before applying for amended certificates, we noted one instance in which an individual's license had been revoked and another in which the individual's license had been suspended. However, in both of these cases, we could find no evidence the department was aware of the adverse information concerning these individuals.

In addition, the department does not coordinate with the SEC in using a unique identifying system to identify the individuals the department is trying to screen. The lack of a unique system sometimes results in the department receiving adverse information on a person and not being certain that the information applies to the person the department is screening. For example, when the SEC responded with adverse information for one of the names we submitted, a Michael A. Smith, we had no way of verifying if the information pertained to the same Michael A. Smith we inquired about. In these situations, the department asks the person being screened if the adverse information applies to them and attempts to gather other information to verify that the applicant is, in fact, the same person.

Finally, the department either does not always contact the agencies as it should or it does not adequately document the information it receives from these agencies.

The Costs of California's Guarantee Association for Property and Casualty Insolvencies Are Increasing

California established the California Insurance Guarantee Association (CIGA) and the California Life Insurance Guarantee Association (CLIGA) to pay the covered claims of member property and casualty and life insurers that become insolvent.

Because the legislation establishing the CLIGA took effect as recently as January 1991, insufficient data existed for us to analyze the costs of life insurers' insolvencies. However, we did determine that, as the frequency of property and casualty insolvencies has generally increased over time, so has the financial cost of paying for these insolvencies. In 1986, the CIGA paid more than $67.1 million for losses and expenses of insolvent insurers. By 1989, that amount had increased to approximately $173 million. This amount represents an increase of 157 percent in the amounts paid out by the CIGA over three years.

Consequently, the CIGA has had to charge its member insurers more in assessments. In 1986, the CIGA collected approximately $122 million in assessments from its member insurers. By 1989, that amount had risen to more than $253 million. This amount reflects a 108 percent increase in the assessments the CIGA collected from its member insurers. These member insurers then pass the cost of these assessments on to the insurance buying public in the form of premium surcharges.

Corrective Action

The department has made or will make a number of changes aimed at improving its surveillance and regulation of insurers. Among those actions already taken is the reorganization of certain of the department's regulatory divisions and bureaus under two newly established positions. The persons filling these positions will report directly to the chief deputy commissioner and become members of the commissioner's executive staff. The department has also drafted a variety of pending and recently adopted legislation to improve its regulatory authority over entities and activities identified as characteristic of the types of factors causing past insolvencies.

Recommendations

To improve the department's regulatory system and to ensure that the department takes prompt and decisive action when it detects problems with an insurer, the department should take the following actions:

- Develop guidelines for creating corrective action plans to address the problems of insurers in danger of insolvency. These corrective action plans should specify a timeframe within which the insurer has to correct the problems the department identifies. These plans should also outline the alternative actions the department will take if the insurer does not adhere to the timeframe;

- Revise its method of investigating officers, directors, and major shareholders of insurers applying for new and amended certificates. The new method should include the use of periodic requests for information from other agencies, a unique identifying system for obtaining information from the Securities and Exchange Commission about specific individuals, and better documentation of the information obtained; and

- Institute a more effective and assertive communication system with other state regulators.

To improve the department's regulatory practices aimed at questionable investments, the department should pursue the following actions:

- Use the commissioner's broad regulatory authority to encompass risky investment practices;

- Require each insurer's board of directors to develop investment policies as a guide for investment decisions; and

- Review each insurer's investments to ensure the company is adhering to its stated investment policies.

To improve the department's regulatory practices aimed at improper affiliate transactions, the Legislature should modify the California Holding Company Act, instituting substantial civil penalties (fines) for violations of the act.

To improve the department's regulatory practices aimed at loss reserve deficiencies, the department should require actuaries to test the reliability of insurers' data as part of their certification of reserves.

To strengthen the department's regulatory authority aimed at improper reinsurance and poor use of managing general agents, the Legislature should amend recently passed laws regarding reinsurance intermediaries and managing general agents. These amendments would provide for reimbursement or restitution to an insurer for any losses reinsurance intermediaries and managing general agents cause by violating the laws.

To improve the department's regulatory practices concerning poor underwriting, the department should integrate consumer complaint data and trend analysis in prioritizing and scheduling companies for field rating and underwriting examinations.

To improve the department's regulatory practices aimed at excessive agents' balances, the department should actively enforce the recently adopted managing general agents law, part of which requires the monthly remittance of funds owed to an insurer.

Agency Comments

The Department of Insurance generally concurs with the conclusions and recommendations in our report. The department observed that, with one exception, the problems we identified preceded the current insurance commissioner's elected term, and the department has already taken and will continue to take appropriate corrective action.

The California Insurance Guarantee Association believes our informational chapter concerning its operations are accurate.

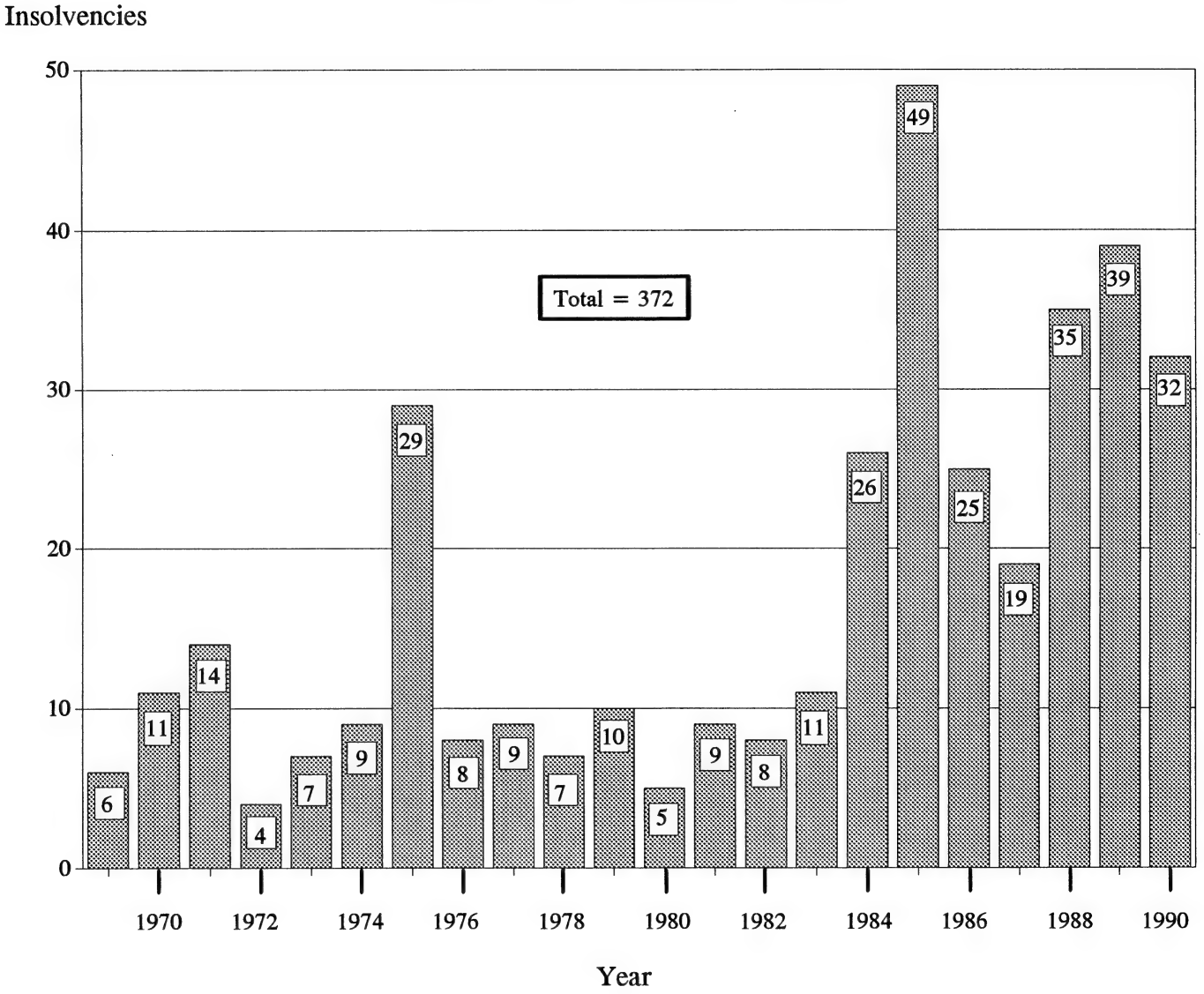
Introduction

The Department of Insurance (department) is responsible for protecting policyholders, beneficiaries, and the public from losses due to the insolvency of insurance companies (insurers) authorized to conduct business in California. Insolvency is a financial condition in which an insurer is unable to pay claims as they fall due in the normal course of business. A.M. Best, an agency that provides ratings and financial information on the insurance industry, in June 1991, reported on insurance company insolvencies. In its report, A.M. Best defined an insolvent company as any insurer domiciled in the United States against which the insurance department of its state of domicile has taken action for reasons of financial impairment. State actions include administrative orders, supervision, suspension, receivership, conservatorship, liquidation, or any other form of action that restricts or limits an insurer's freedom to conduct business.

An administrative order is an order the insurance commissioner obtains through an administrative court that directs an insurer to correct or eliminate any condition deemed hazardous to the insurer's policyholders, creditors, or the public. Receivership is a court-ordered appointment of the commissioner to administer an insurer's business affairs pending litigation. Under conservatorship, an insurer experiencing financial or other problems is placed under court-ordered regulatory control to conserve company assets until the insurer's status is finally determined. Liquidation is a process in which an insolvent company's assets are converted to cash and applied toward its outstanding debt.

According to the insolvency study completed by A.M. Best, 372 property and casualty insolvencies have occurred nationwide from 1969 through 1990, as illustrated in Figure 1. A.M. Best noted that the anticipated guarantee association payments for insolvencies occurring nationally from 1969 through 1989 will total approximately $4.4 billion. This amount does not include the future costs for insurers recently declared insolvent, but not yet placed into liquidation. We define guarantee association payments on page 10.

Property and Casualty Insolvencies From 1969 Through 1990



Source: A.M. Best, Special Report, June 1991.

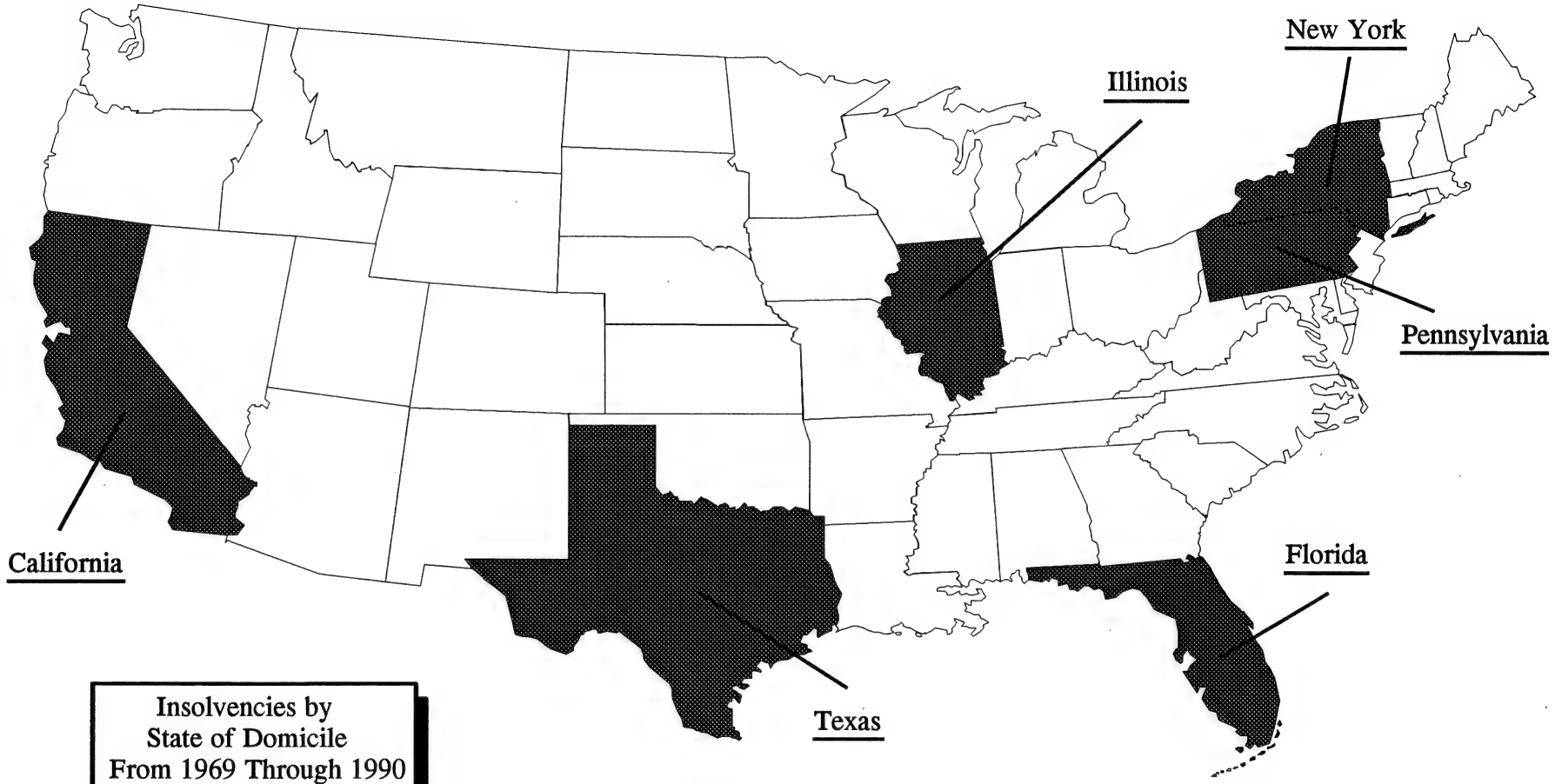
Figure 1

Of the 372 property and casualty insolvencies occurring nationwide, six states accounted for 50 percent of them. California, one of the six states, ranked second with 35 insolvencies during the 22 years from 1969 through 1990. Only Texas had more insolvencies with 47. Figure 2 shows the six states and the number of insolvencies for each one.

To protect California consumers, the department regulates nearly 1,900 insurers and approximately 300,000 individuals licensed to conduct insurance business in California. These insurers collect approximately $50 billion in premiums yearly from their policyholders. As part of its regulatory responsibility, the department maintains solvency surveillance by screening would-be entrants into the field of insurance, analyzing insurers' financial statements, conducting field examinations, regulating rates, investigating consumer complaints, and enforcing compliance with the California Insurance Code.

In November 1988, California's voters approved Proposition 103, which called for the statewide election of the insurance commissioner for a four-year term. The insurance commissioner directs the department. Before the approval of Proposition 103, the governor appointed the insurance commissioner, subject to legislative confirmation. The first elected insurance commissioner took office in January 1991.

Six States Accounting for Half of the 372 Insolvencies Nationwide From 1969 Through 1990



Insolvencies by State of Domicile From 1969 Through 1990	
Texas	47
California	35
Pennsylvania	35
New York	30
Illinois	22
Florida	18

Figure 2

The Divisions and Bureaus Involved in the Department's Regulatory System

Many divisions and bureaus within the department participate in regulating insurers. These divisions and bureaus include the field examination division, financial analysis division, actuarial division, conservation and liquidation division, claims services bureau, field rating and underwriting bureau, investigation bureau, and corporate affairs bureau. In Figure 3, we discuss the main functions of these divisions and bureaus and their staffing levels as of September 1990.

The Main Divisions and Bureaus of the Department of Insurance

Field Examination Division

Conducts triennial on-site examinations of all domestic insurers;

Voluntarily participates in examinations of foreign and alien insurers transacting business in California;

Conducts examinations of domestic insurers as financial conditions warrant;

Conducts initial examinations of all insurers seeking to do business in California.

Positions as of September 1990:

1 chief
3 supervisory examiners
52 examiners

Financial Analysis Division

Makes certain that insurers are financially stable;

Analyzes and maintains surveillance of financial solvency of insurers authorized in California;

Analyzes holding company transactions and acquisitions;

Develops and coordinates reinsurance regulatory policies;

Performs reinsurance audits and analyses;

Assists the corporate affairs bureau in screening individuals applying for new or amended certificates authorizing them to transact insurance business in California.

Positions as of September 1990:

1 chief
4 supervisory examiners
28 examiners
3 investigators
2 reinsurance specialists
1 senior life actuary

Actuarial Division

Furnishes actuarial advice during examinations of insurers;

Certifies the valuation of policy reserves held by California-domiciled life insurers.

Positions as of September 1990:

1 chief
3 senior actuarial statisticians
2 senior casualty actuaries
1 supervising life actuary
3 senior life actuaries
1 associate life actuary
3 actuarial statisticians

Figure 3 (page 1)

Corporate Affairs Bureau

Processes new and amended certificates authorizing insurers to transact insurance business in California;

Conducts investigatory, administrative, and cease-and-desist hearings;

Monitors insurers and other licensed entities for compliance with applicable laws and regulations.

Positions as of September 1990:

1 supervising staff counsel
12 staff counsel
3 legal analysts
3 legal assistants

Field Rating and Underwriting Bureau

Conducts on-site examinations of insurers that sell property and casualty insurance;

Confirms compliance of the underwriting rules, guidelines, policy forms, and rating plans with state laws and regulations;

Verifies that insurers' rates and rating plans have been filed with and approved by the rate filing bureau.

Positions as of September 1990:

1 supervising insurance rate analyst
26 insurance rate analysts

Investigation Bureau

Ensures that insurers and other persons selling insurance in California do not violate state laws;

Investigates complaints of fraud, misrepresentation, dishonesty, other illegal acts, and incompetence.

Positions as of September 1990:

1 chief investigator
3 supervising insurance investigators
36 investigators

Claims Services Bureau

Investigates complaints and questions related to the handling of insurance claims;

Conducts on-site inspections of claims documents and insurers' processing procedures to ensure compliance with state law.

Positions as of September 1990:

1 chief
1 assistant chief
31 insurance policy officers

Conservation and Liquidation Division

Conserves and operates financially troubled insurers;

Liquidates insurers that cannot be conserved.

Positions as of September 1990:

1 chief
1 assistant chief
1 senior examiner
2 associate examiners

Figure 3 (page 2)

California Guarantee Associations

California established the California Insurance Guarantee Association (CIGA) in 1969 and the California Life Insurance Guarantee Association (CLIGA) in 1991 for the purpose of paying the covered claims of member property and casualty and life insurers who become insolvent. These payments are known as guarantee association payments. All property and casualty insurers transacting business in California must be members of the CIGA, and all life insurers transacting business in California must be members of the CLIGA. The CIGA covers claims associated with most property and casualty lines while the CLIGA covers claims associated with the various lines of life insurance.

As of June 1990, the executive director of CIGA estimated that the total projected cost for all property and casualty insolvencies in California since 1985 will total approximately $1.1 billion. This projected cost represents all claims and expenses, which include the losses incurred but not yet reported to CIGA, that CIGA will eventually pay. We could not analyze data regarding the costs of life insurers' insolvencies because the legislation establishing the CLIGA took effect as recently as January 1991, and so there was insufficient data.

National Association of Insurance Commissioners

The National Association of Insurance Commissioners (NAIC), which was formed in 1871, is a voluntary organization of the chief insurance regulatory officials of the 50 states, the District of Columbia, and four United States' territories. As an organization, the NAIC's purpose is to help insurance commissioners protect the interests of insurance policyholders. The NAIC plays an important role in coordinating and improving state insurance regulatory activities by conducting financial analyses of insurers' statements. These analyses then are used to prioritize insurers for further state regulatory review by what is known as the Insurance Regulatory Information System (IRIS). The NAIC maintains data bases on insurers and individuals involved with the insurance business, develops model laws and regulations to promote uniformity of standards among states, coordinates multistate examinations of insurers, and serves as a clearing house for information on companies and individuals possibly involved in questionable or fraudulent activities.

Historically, one of the NAIC's principal functions has been to develop model laws for the states' consideration. These model laws are designed to improve state insurance regulation and promote uniformity of financial standards among states. However, the NAIC has no authority to compel states to adopt and implement the model laws even though it considers them essential for effective solvency regulation. As of April 1991, the NAIC had developed approximately 200 model laws.

In June 1990, the NAIC adopted a formal accreditation program to encourage state insurance departments to comply with its financial regulatory standards for effective solvency regulation. As part of its program, the NAIC has identified 16 model laws and regulations that a state should adopt for that state's insurance department to become accredited. As part of his testimony on the subject of insurance regulation given before a subcommittee of the House of Representatives, an assistant comptroller general of the United States General Accounting Office (GAO) stated that, as part of its work, the GAO tabulated each state's adoption of 14 of the model laws and regulations referred to in the NAIC's financial regulatory standards. The GAO did not include two of the NAIC's model laws relating to state guarantee funds. Table 1 shows California's efforts to adopt the 14 model laws and regulations as of April 1991.

Table 1 **California's Adoption of NAIC Model Laws and Regulations Required for Accreditation**

	Date NAIC Adopted	Model or Similar Legislation or Regulation Adopted[b]	Related Legislation or Regulation Adopted[b]	Pending Legislation or Regulation[b]	No Current Legislation or Regulation Adopted[b]
Examination authority[a]	1991		X		
Regulation to define standards and commissioner's authority for companies in hazardous financial condition	1985				X
Holding Company Act	1969	X			
Holding Company Regulation	1971	X			
Standard Valuation Law	1943	X			
Credit for Reinsurance Act	1984		X		
Regulation for life reinsurance agreements	1986				X
Certified Public Accountant Audit Regulation	1980		X		
Rehabilitation and Liquidation Model Act	1978		X		
Insurance Regulatory Information System Model Act	1985			X	
Risk Retention Act	1983	X			
Business Transacted With Producer-Controlled Property and Casualty Insurer Act[a]	1988				X
Managing General Agent Act[a]	1989			X	
Reinsurance Intermediaries Act[a]	1990			X	

[a] States have until 1992 to adopt the law.

[b] Information as of April 1991.

As shown in Table 1, as of April 1991, California had yet to adopt three of the model laws and regulations required for NAIC accreditation. California also had legislation pending on three model laws. Two of the three pending model laws were of particular importance within the context of this report, the Managing General Agent Act and the Reinsurance Intermediaries Act. Since April 1991, California has adopted legislation related to these two acts, although the legislation omits some aspects of the NAIC's model laws.

A managing general agent is an individual who manages all or part of the insurance business for an insurer, underwrites premiums, and adjusts or pays claims. The Managing General Agents Act requires all these agents to be licensed and imposes many requirements and restrictions on both the agent and the company for which it is acting. Most important, the act requires that a written contract between the agent and the insurer be filed with the insurance department. The contract would require the insurer to monitor and control the agent's activities. The act also limits the amount of insurer funds the agent can hold and requires adequate records to be maintained. In addition, based on loss experience, it restricts the payment of commissions payable and requires independent actuarial certification of loss reserves the agent establishes. (Loss reserves are funds insurers hold to pay for present and future losses.) The act further requires the insurer to conduct semiannual on-site reviews of the underwriting and claims processes. In most instances, the act prohibits managing general agents from contractually committing the insurer to a reinsurance agreement. Reinsurance is a form of insurance for an insurance company. Under a reinsurance contract, the primary insurer transfers or "cedes" to another insurer (the reinsurer) all or part of the financial risk of loss accepted in issuing insurance policies to the public. The reinsurer, for a premium, agrees to indemnify or reimburse the ceding company for all or part of the losses the latter may sustain from claims it receives. The act also authorizes the commissioner to examine the managing general agent's books and records, requires a bond for the protection of the insurer, and orders reimbursement for any loss incurred by the insurer as a result of a violation of the act by the agent.

The Reinsurance Intermediaries Act requires reinsurance brokers and managers to be licensed as insurance producers. (A reinsurance intermediary is a broker or manager who performs a variety of activities on behalf of a ceding insurer in the case of a broker, or on behalf of a reinsurer in the case of a manager.) The act imposes strict recordkeeping and reporting requirements. It prohibits the reinsurance manager from entering into retrocessions in most instances as well as from committing the reinsurer to participate in reinsurance syndicates. (Retrocession is a transaction whereby a reinsurer cedes to another reinsurer all or part of the reinsurance it has assumed.) Moreover, the reinsurer is required to obtain annual, independently prepared, financial statements from its reinsurance manager and a certification of loss reserves on business the manager produces. Further, the act authorizes the commissioner to examine the books and records of the reinsurance intermediary and requires that the reinsurance manager's actions are deemed to be the company's actions on whose behalf the manager is acting. The act further authorizes the commissioner to order the reinsurance intermediary to make restitution for net losses incurred attributable to its violations of the act. Although California has since adopted legislation similar to both the Managing General Agent Act and the Reinsurance Intermediaries Act, California's versions do not provide for reimbursement or restitution on the part of managing general agents or reinsurance intermediaries violating the acts.

The Securities Valuation Office

In 1949, the NAIC created the Securities Valuation Office (SVO) for the purpose of providing state regulators and insurers with a source for obtaining uniform prices and quality ratings for insurers' securities holdings. Insurers use these prices and quality ratings in preparing their annual statements, which are filed with state insurance regulators.

Specifically, insurers and insurance regulators use the SVO's ratings to help establish values for securities such as stocks and bonds. The establishment of values for these securities is important for insurers whose ability to write insurance is based on the adequacy of their surplus. (Surplus is the amount by which the

assets of an insurer exceed its liabilities less capital.) An insurer's surplus is, in turn, influenced by the value of its securities. For example, most life insurers must establish a mandatory securities valuation reserve (MSVR), a component of an insurer's liabilities, to anticipate any losses associated with bond and stock investments. The amount of the required MSVR is dependent on the SVO ratings assigned to the individual bonds and stocks making up the insurer's investment. Generally, the lower the bond or stock's rating, the greater the required MSVR. Meanwhile, instead of establishing reserves to recognize the relative risks associated with bonds and stocks that the SVO has rated as of lower quality, a property and casualty insurer is required to value its securities using the lower of cost or market value, potentially reducing the value of its assets.

According to its executive director, the SVO is responsible for rating newly purchased securities, reevaluating securities annually, maintaining a list of banks issuing letters of credit that meet NAIC standards, and determining if the valuation a parent company assigns to its subsidiary, controlled, or affiliated company is reasonable and appropriate. Although the SVO has no statutory power to force insurers to comply with its rules and regulations, state regulators require insurers to file the NAIC's annual statement forms. In effect, this requirement forces insurers to use the SVO's ratings and values.

Further, the SVO maintains a database of publicly traded and privately placed securities owned by United States' insurers. A publicly traded security is one that has been registered with the Securities and Exchange Commission (SEC) and offered to the public by a securities underwriting dealer. A privately placed security is one that is exempt from registration with the SEC and is known as a "restricted security" because it cannot be sold to the public in the usual way by a brokerage transaction. The securities in the database include government, municipal, and corporate bonds and common and preferred stocks. The database lists approximately 65,000 securities from about 25,000 different issuers. In its yearly *Valuation of Securities* manual, the SVO publishes the market prices and NAIC rating designations for all bonds and stocks owned by insurers domiciled in the United States when such securities have been filed with the SVO.

Scope and Methodology

The purpose of this audit was to evaluate the department's regulatory practices aimed at the early detection of problems that can lead to insurers' insolvency. We also evaluated the ability of the CIGA to pay the covered claims of insolvent property and casualty insurers. However, we could not perform a financial analysis of the CLIGA because it did not begin operations until January 1991. In addition, we attempted to review the operations of the NAIC and the SVO but were unable to do so for the reasons indicated on pages 18 and 19.

In conducting this audit, we reviewed the pertinent laws, regulations, and policies relating to the department's regulatory system. We interviewed personnel of the department's financial analysis division, field examination division, claims services bureau, field rating and underwriting bureau, investigation bureau, corporate affairs bureau, and conservation and liquidation division. We also interviewed the liquidator of Mission Insurance Company, the conservator of Pacific Standard Life Insurance Company, and the executive directors of the CIGA and the SVO.

To evaluate the department's regulatory system, we reviewed a sample of 14 insolvent insurers: 9 domestic insurers and 5 foreign insurers. A domestic insurer is an insurer incorporated in California. A foreign insurer is an insurer incorporated in another state. Four of the domestic insurers were specifically identified for us to review. For the remaining domestic insurers, we randomly selected 5 from those domestic insurers declared insolvent after 1985 whose estimated cost of insolvency exceeded $3.5 million. For the foreign insurers, we selected a sample of 5 from all foreign insurers declared insolvent after 1985 whose estimated cost of insolvency exceeded $3.5 million and that were domiciled in states participating in a joint audit sponsored by the National State Auditors Association. The purpose of this joint audit was to evaluate the strengths and weaknesses of different states' regulatory systems and to recommend alternatives to improve insurance regulation and help prevent industry abuses from occurring. New York was the state in charge of the joint audit, with the following ten other states participating:

California	Missouri
Colorado	New Mexico
Florida	North Carolina
Illinois	Tennessee
Maryland	Texas

For each of the 14 insolvent insurers, we reviewed documents in the department's files to determine the main causes of the insurers' failures.[1] We provide a list of these causes in Table 2 on page 28. We then conducted a detailed review of the department's regulatory actions regarding each of the failed insurers. We focused our review on the main causes contributing to each insurer's eventual insolvency and the department's surveillance efforts and regulatory actions with respect to those main causes. In addition, for each of the foreign insurers, we contacted the auditor general or state comptroller in the insurer's domicile state. We requested them to conduct a review of the files located in their insurance departments to substantiate the main causes of the foreign insurers' insolvencies and to evaluate the surveillance efforts and regulatory actions the domicile states' insurance departments took with respect to those causes.

We also submitted a list with the names of the directors and officers of the 14 insolvent insurers to the NAIC and the Securities and Exchange Commission (SEC). We asked these organizations to review their respective files and databases for any adverse information concerning these individuals.

To evaluate the ability of the CIGA and the CLIGA to pay the covered claims of insolvent property and casualty and life insurers, we identified the CIGA's and the CLIGA's powers and duties in assessing member insurers, paying the covered claims of

[1]Because the department has procedures for periodically purging from its files documents it does not consider critical, we based our review on the documents the department retained. For example, the financial analysis division's procedures require all documents be retained for at least five years and critical documents for even longer.

policyholders, and interacting with the liquidators and guarantee associations of other states. We then determined the amount of claims and other expenses the CIGA paid out for the years between 1986 and 1989 and the amount of assessments the CIGA collected from member insurers during that same period. We also obtained from the CIGA an estimate of the total costs of covered claims for all property and casualty insurers that have entered into liquidation since 1985 and for which the CIGA was responsible. We could not perform these financial analyses for the CLIGA because it did not begin operations until January 1991.

To identify whether any trends had developed in the insolvencies of property and casualty insurers, we obtained and reviewed a study A.M. Best conducted on property and casualty insolvencies that have occurred since 1969. The insolvency trends the study identified included characteristics such as an insurer's size, years of operation, growth in premium volume written, and lines of insurance business written. Based on the trends A.M. Best identified, we analyzed whether the department had also identified the trends and adjusted its scheduling of field examinations accordingly. The department conducts field examinations of domestic insurers on a triennial basis except when financial or other conditions warrant examinations at shorter intervals. We reviewed a sample of our insolvent domestic property and casualty insurers and the dates of their field examinations. We found that, in general, the department's field examination division followed its regular triennial schedule for these insurers. Consequently, we could not find any evidence that the insolvency trends identified by A.M. Best were also identified by the department or used to influence the way in which the department scheduled its field examinations of the insurers we reviewed.

To determine the adequacy of the methods the SVO used in ranking and valuing the securities and other investments insurers held and showed on their financial statements, we interviewed the executive director of the SVO and obtained background material concerning the SVO's function. We also intended to test the rankings and valuations the SVO assigned. However, the NAIC refused to give us access to the data supporting the valuations of

securities and other investments insurers made because the data was confidential. Therefore, we were unable to form any conclusions as to the adequacy of the ranking and valuation methods the SVO used.

In addition, we intended to test the adequacy of the methods the NAIC used in placing insurers that may be experiencing financial difficulty on its watchlist. However, the NAIC proposed that any granting of access to the data supporting these watchlists be deferred until after our report was released. Therefore, we were unable to form any conclusions as to the adequacy of the methods the NAIC used in placing insurers on its watchlist. The NAIC also deferred the granting of access to several other states participating in our nationwide review.

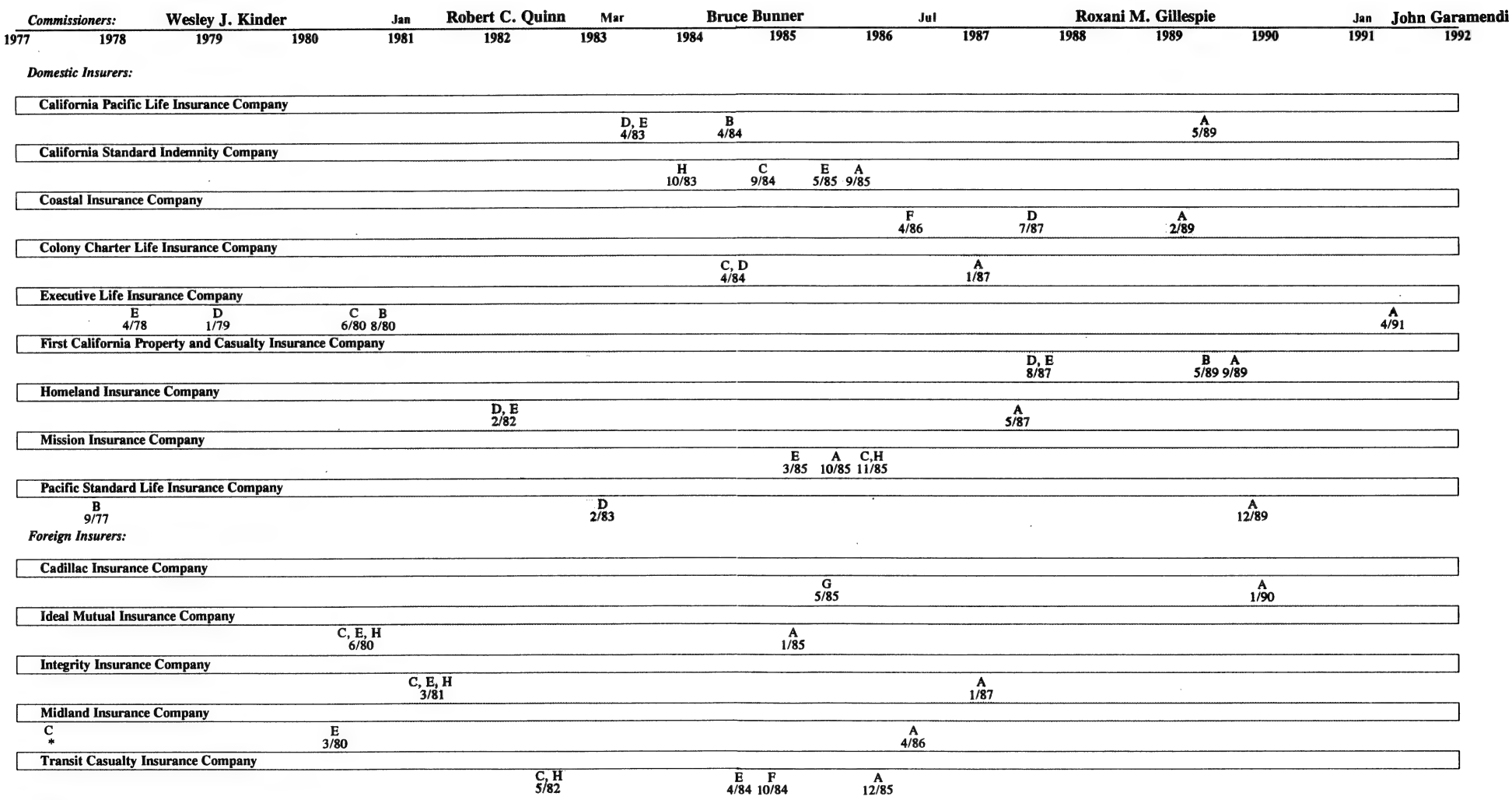
Chapter 1 The Department of Insurance Did Not Always Take Prompt and Decisive Action After It Discovered Problems Leading to Insurers' Insolvencies

Chapter Summary

During our review of a sample of 14 insolvent insurers, we found that, in general, the California Department of Insurance (department) identified the problems contributing to the insolvencies. Seven of the problems we identified were questionable investments, improper reinsurance, improper affiliate transactions, loss reserve deficiencies, poor underwriting, poor use of managing general agents, and agents' high balances. However, the department did not always take prompt and decisive action after it detected the problems. Instead of taking effective regulatory action to correct these problems and mitigate the harm to policyholders, the department relied upon informal and time-consuming discussions that failed to yield any appreciable results.

The figure on the following page shows the 14 insolvent companies, the year of conservatorship for each company in California or its domicile state, the year the department detected each potentially hazardous condition, and the five insurance commissioners in charge of the department during the period we reviewed.

Overview of the 14 Companies We Reviewed and the Year of Their Insolvency



Legend

A Conservation	E Underreserving
B Questionable Investments	F Poor Underwriting
C Improper Reinsurance	G Agents' High Balance
D Improper Affiliate Transactions	H Poor Use of Managing General Agents

* Improper Reinsurance discovered in May of 1974

Figure 4

The Department's Regulatory Activities

The California Insurance Code grants broad authority to the insurance commissioner in regulating the insurance industry. For example, Section 1065.1 of the California Insurance Code states that whenever the insurance commissioner has reasonable cause to believe, and determines after a public hearing, that any person is conducting insurance business in California improperly, the commissioner may serve any reasonably necessary order to correct, eliminate, or remedy such a condition. Improperly conducted insurance business is any that threatens to render the business insolvent, that is hazardous to its policyholders, creditors, or the public, or that commits or engages in any act, practice, or transaction that subjects the person practicing improper insurance business to conservation or liquidation proceedings. Further, Section 1065.2(a) states that whenever it appears to the commissioner that any of the activities previously discussed in Section 1065.1 exist, and that irreparable loss and injury to the property and business of a person conducting insurance in this State has occurred or may occur unless the insurance commissioner acts immediately, the insurance commissioner may issue and serve this person an order requiring the person to cease and desist from further engaging in the acts, practices, or transactions causing such a condition.

In addition, Section 1011 of the California Insurance Code states that the insurance commissioner has the authority to go to a court and obtain an order to conserve a company to prevent further decline in the company's financial condition pending a final determination of its status.

Another major responsibility of the insurance commissioner, shown in Section 717 of the California Insurance Code, states that before granting a new or amended certificate of authority to any applicant, the insurance commissioner should consider certain qualifications of the applicant. (An insurer needs a certificate of authority to transact insurance business in California.) Among other things, the commissioner should review the following:

- Capital and surplus;
- Lawfulness and quality of investments;

- Financial stability;
- Reinsurance arrangements;
- Management competency, character, and integrity; and
- Hazard to policyholders or creditors.

Finally, Section 700(c) of the California Insurance Code states that after the issuance of a certificate of authority, the holder must continue to comply with the business requirements described in the California Insurance Code and other California laws.

The Hazardous Conditions That Can Cause Insolvency

Regulatory activities are designed to identify hazardous conditions that can lead to insurance company insolvencies. Based on our review of 14 failed insurance companies, the department's regulatory activities generally identified the hazardous conditions contributing to each company's insolvency before the company failed. We identified seven hazardous conditions that can cause insolvencies, one or more of which were present in each of the 14 failed insurance companies we reviewed. The following table lists the companies we studied and the hazardous condition or conditions they exhibited.

Table 2

Hazardous Conditions That Caused Insolvencies

Companies	Questionable Investments	Improper Reinsurance	Improper Affiliate Transactions	Under-Reserving	Poor Underwriting	Poor Use of Managing General Agents	Agents' High Balances
Domestic Insurers:							
California Pacific Life Insurance Company	X		X	X			
California Standard Indemnity Company		X		X			X
Coastal Insurance Company			X		X		
Colony Charter Life Insurance Company		X	X				
Executive Life Insurance Company	X	X	X	X			
First California Property and Casualty Insurance Company	X		X	X			
Homeland Insurance Company			X	X			
Mission Insurance Company		X		X		X	
Pacific Standard Life Insurance Company	X		X				
Foreign Insurers:							
Cadillac Insurance Company							X
Ideal Mutual Insurance Company		X		X		X	
Integrity Insurance Company		X		X		X	
Midland Insurance Company		X		X			
Transit Casualty Insurance Company		X		X	X	X	

Although the department's regulatory activities were generally able to identify hazardous conditions present in the companies we reviewed, the department was unable to ensure the companies promptly took the necessary actions to correct those conditions. The failure to correct these hazardous conditions ultimately contributed to the failures of the companies we reviewed.

The chief of the financial analysis division stated that, historically, the department has attempted to resolve its initial concerns about insurers' financial problems with informal actions, if circumstances so allow. Such informal actions can range from requiring minor corrective changes in operations or underwriting to requiring complete cessation of writing. Informal actions are perceived to be less stressful to an insurer and may prevent the aggravation of problems policyholders' concerns cause (for example, "runs-on-the-bank" by policyholders after hearing bad news, as was the case with First Capital Life and Mutual Benefit Life).

According to the chief of the financial analysis division, a series of informal actions against an insurer is meant to progressively tighten control over the insurer. However, the danger of taking such a series of informal actions is that they may not be sufficient in total to alleviate the financial problems of an insurer, and when that occurs, a subsequent formal action may then appear to have been taken too late. In a case where an informal action is unsuccessful, it may also appear that the department has been too lenient in its approach or that it has not acted aggressively to address severe financial problems. Therefore, according to the chief, the trend at the department has been toward taking formal actions at earlier stages when problems are discovered. Such actions include cease-and-desist orders and conservatorships to control the deterioration of the financial condition of troubled insurers.

Delaying prompt and effective regulatory action increases the costs of insolvencies. First, if insurers are allowed to continue writing new policies during the period in which the department tries to informally negotiate corrective action, then more policyholders will be adversely affected if an insurer fails. Second, the financial condition of the problem insurer may continue to

deteriorate during this interim period. In cases such as Pacific Standard, a delay allowed the parent company of the insurer to remove valuable assets from the company. The financial consequence of such an action is ultimately an increase in the financial cost of the insurers' insolvencies. Third, the costs of the insolvencies are passed through to the policyholders of healthy companies in the form of higher insurance rates. Another effect of insolvencies is that policyholders whose policies are not covered by a guarantee fund can lose their life savings. For these policyholders, the only hope of receiving even partial payment is to list themselves as unsecured general creditors. Unsecured general creditors have a lower priority in the distribution of a failed company's liquidated assets.

The Department Did Not Take Prompt and Decisive Action When It Detected Insurers' Questionable Investments

During our review of a sample of 14 insolvent insurers, we found that questionable investments contributed to 4 of the insolvencies. We have defined questionable investments as investments insurers make that do not provide protection to policyholders. Imprudent investments are hazards to an insurer's solvency when investment losses, whether realized or unrealized, jeopardize the insurer's ability to pay policyholders' claims when due. A realized loss is the difference between the net proceeds from the sale of a marketable security and its cost. An unrealized loss is the difference between the current market value and the purchase price of a marketable security without regard to its sales price. For these 4 insolvent insurers, the department failed to take prompt and decisive actions in 3 cases even though it had for some time detected problems involving investments. In the following pages, we describe an example of the department's lack of action. For a complete discussion of each of the companies we reviewed, see Appendix A.

Executive Life Insurance Company

On April 11, 1991, the California insurance commissioner found Executive Life Insurance Company (ELIC) to be operating in a hazardous manner and placed it under conservatorship. In his statement to the United States Committee on Commerce, Science,

and Transportation, given on May 7, 1991, the commissioner cited ELIC's investments in high-yield non-investment grade bonds, commonly known as "junk bonds," as one of the main determinants in his move to conserve the company. Investments in too many of these high-yield bonds can mean a company has too much risk to completely cover. These bonds are rated "non-investment" according to the grades established by Standard & Poor's, which rates bonds according to their investment worth. The "non-investment" grade falls below the four highest grades Standard & Poor's uses.

Although the department did not conserve ELIC until 1991, it began to have questions regarding ELIC's investments as early as 1980. Specifically, through a review of the company's financial statements, a department examiner noted that ELIC's premium volume had increased from $95 million at December 31, 1979, to more than $300 million at June 30, 1980, and according to information obtained from ELIC, was derived primarily from annuities. Premiums represent the money an insurer collects for the insurance policies it issues. An annuity is an insurance product investment for which a person receives fixed payments over a set period of time. The sale of annuities can threaten an insurer's solvency if, for instance, an insurer guarantees a higher rate of return to its annuity policyholders than it is able to earn on the investments it makes. Then, the payments could create a drain on the insurer's surplus.

In August 1980, the examiner indicated that the department would question ELIC on the type and nature of these annuities; the interest rates being paid; whether the rates were guaranteed and, if so, for how long; and the type of investment vehicles ELIC was using to fund the annuity payments. However, we could not find any evidence indicating the department ever followed up to get answers to these questions. Further, the National Association of Insurance Commissioners (NAIC), through its analyses of key financial ratios computed from ELIC's 1980 and 1981 annual statements, found that ELIC's change in premium ratio exceeded industry norms by a wide margin during both years. According to the NAIC, such a condition could indicate that the insurer may not have the knowledge and experience required to maintain financial

strength while its operations are going through a dramatic change. In 1981, and again in 1982, the NAIC recommended that ELIC be accorded immediate regulatory attention based on its financial performance in 1980 and 1981. Despite the concerns the department's examiner raised and the recommendations the NAIC made, we could find no documentation of the department placing any extra emphasis on its review of ELIC's practices beyond its normal review of the company's financial statements.

Furthermore, in 1982, a former insurance commissioner received a copy of an anonymous letter written to the enforcement division of the Securities and Exchange Commission alleging ELIC's involvement in securities violations and improprieties in its dealings with Drexel Burnham Lambert, Inc. (Drexel). Drexel is a securities investment brokerage firm ELIC used to buy and sell securities on its behalf. The letter stated ELIC and another affiliate, Executive Life of New York (ELNY), were depleting their assets as a result of buying securities at highly inflated prices from Drexel's high-yield bond department. These transactions allowed Drexel to earn a profit of more than $30 million over 18 months. The letter further alleged that after selling securities to the insurers at big markups, Drexel would buy back any securities that appreciated in value, thus providing the two insurers with a small profit. However, any securities that depreciated in value would be left in the insurers' portfolios. According to the letter, as a result of this type of trading in junk bonds, both insurers suffered losses and had sizable holdings in at least 12 companies that were bankrupt at that time.

The letter went on to describe examples of alleged improprieties engaged in by Drexel, ELIC, and First Executive Corporation, ELIC's parent company. Even though a former insurance commissioner requested that his staff review the letter and respond to him as soon as possible, we could not find any evidence the department pursued any of the allegations contained in the letter. Furthermore, according to the chief of the financial analysis division, his division records did not indicate whether the division made any specific follow-up efforts to confirm or deny the letter's allegations or to determine whether the Securities and Exchange Commission investigated the charges contained in the letter.

In December 1984, while conducting an examination of ELIC, the lead examiner of the department's examination team informed the department's chief examiner that one of his staff believed ELIC had overpaid on stock and bond purchases and had been underpaid on the sales of these securities by as much as a quarter of a billion dollars in 1983. However, we could find nothing in the files or in the examination report covering 1983 to prove the department had pursued this issue.

In May 1985, the department completed its report of examination on ELIC covering December 31, 1980, through December 31, 1983. The department's examiners found that ELIC's president controlled ELIC's overall investment philosophy and individual investment decisions. In addition, the report stated that the president was solely responsible for approving all brokers' invoices and that ELIC purchased and sold approximately 90 percent of its securities through one broker, Drexel. The department recommended that ELIC's newly formed internal audit department periodically review ELIC's investment operations because of their importance and structure. The report further recommended that ELIC's board of directors designate a member of the executive committee to share responsibility for approval of brokers' invoices. However, in our review of the subsequent examination of ELIC and other documentation, we found no indication the department confirmed whether or not those recommendations were ever implemented.

The report also noted that bonds represented 79 percent of total admitted assets at December 31, 1983. Furthermore, almost 60 percent of those bonds, excluding bonds called private placements, which are not actively traded on a recognized stock exchange, were rated below Standard & Poor's four highest investment grades. As mentioned earlier, bonds rated below the four highest investment grades are commonly referred to as junk bonds. Finally, the report noted that 13 bonds worth more than $38 million were in default, but because the amount was deemed to be immaterial in relation to ELIC's $2.7 billion bond portfolio, the examiners did not adjust the financial statements.

During the remainder of 1985 up until the next field examination requested by the chief of the financial analysis division in March 1987, concerns about ELIC's investment practices continued to be raised from within the department and from external sources. For example, during his analysis of ELIC's annual statements for 1984 and 1985, a department examiner noted that, for both years, investments were unsatisfactory or unusual. In addition, the department received a letter from the Securities Valuation Office (SVO) of the NAIC in July 1985 stating the SVO had recently completed a review of ELIC's industrial and miscellaneous bonds to verify compliance with the SVO's reporting and valuation standards.

As a result of its review, the SVO found that approximately $203 million of ELIC's bonds were never reported for valuation, $92 million in bonds were not valued by the SVO because of insufficient information, and another $152 million in bonds were valued by the ELIC using values other than the ones the SVO established. The letter went on to state that, over the years, the SVO had not had good results in dealing with ELIC, and the company's attempts at compliance were almost always substandard and lacking in documentation. Further, because of the large number of securities acquired by ELIC each year, its noncompliance had become a serious valuation problem for the SVO. The SVO concluded that the annual statement ELIC submitted to the department for 1984 contained many inconsistencies and immediate department action was necessary to bring ELIC into compliance with the SVO's *Valuation of Securities* manual.

In response to the SVO's concerns, the department contacted ELIC's president in October 1985 and instructed him to take immediate corrective action in complying with the SVO's manual. Also, the department instructed him to refile with the department the schedule of bond valuations submitted with ELIC's 1984 annual statement and to carry forward revisions in future filings. After checking ELIC's 1985 schedule of miscellaneous bonds against the SVO's manual, one of the department's examiners concluded that ELIC had substantially complied with the department's request.

Finally, in March 1987, as a result of his analysis of ELIC's annual statements, a department examiner recommended that one of the areas the next scheduled triennial field examination should focus on was ELIC's investment in junk bonds.

In April 1988, the department completed its report of examination of ELIC covering December 31, 1983, through December 31, 1987. However, the report did not indicate that the department's examiners focused their examination on ELIC's junk bonds, as was recommended, nor did it result in any examination adjustments to ELIC's investment accounts. Nevertheless, the department did note that the market value of ELIC's bonds at December 31, 1987, was $312 million less than its book value of $9.1 billion and that junk bonds accounted for 65.3 percent of ELIC's total book value for bonds. In other words, if ELIC were to sell its bond portfolio as of December 31, 1987, it would receive $312 million less than the amortized cost of the bonds. The department further noted that, during 1986 and 1987, ELIC wrote off 41 bonds with a total book value of approximately $142 million and 22 issues of common stocks with a total book value of almost $27 million. Finally, to more clearly disclose the nature of the investment, examiners recommended ELIC reclassify its $131 million contribution to its subsidiary, Executive Life Insurance of New York (ELNY) as "investments in subsidiary" instead of "other invested assets" as was originally reported.

According to a department memorandum, in January 1990, ELIC's president announced that First Executive Corporation, ELIC's parent company, was reducing the recorded value of its junk bond portfolio by as much as $515 million and that reductions pertaining to ELIC represented approximately $364 million of the total. In response to the announcement, the department began a special examination of ELIC. The examination focused on all ELIC's financial affairs, including the negative effect on cash flow that any increase in policy surrenders and any further decline in the market value of ELIC's security investments would have on the company's surplus. In addition, the NAIC formed a working group to discuss non-investment grade bonds. The group met with representatives of the First Executive subsidiaries in

February 1990 to review the financial results for 1989 relating to insurance operations. In the meeting, the group also discussed the various subsidiaries' current financial positions. The group concluded that, in the short term, ELIC and the other subsidiaries had sufficient resources and liquidity.

In March 1990, the department's supervisory insurance examiner of the special examination in progress at ELIC recommended that the department either place ELIC in conservation or make it subject to joint control supervision. The examiner recommended these measures mainly to protect policyholders and to ensure fair and equal treatment for those policyholders surrendering policies. However, the former insurance commissioner did not act on the recommendation. During that same month, the department received the NAIC's synopsis of its review of the 1989 annual statement ELIC filed indicating that ELIC's investment in junk bonds had grown to $6.4 billion as of December 31, 1989.

In April 1990, one of the department's legal counsels noted in a memorandum that ELIC again announced it would have to make further reductions to the value of its investment portfolio. Because of these reductions and a higher than normal rate of policy surrenders, the department monitored the financial status of ELIC daily. In mid-June, the department determined that the market value of ELIC's bonds, as of March 31, 1990, was approximately $1.9 billion less than their book value. Subsequently, the department's review of ELIC's quarterly financial statement for June 1990 showed that ELIC's reserve for losses of securities had decreased $271 million over six months and now amounted to $312 million. The department's examiner concluded the reserve provided little protection relative to the company's weak junk bond portfolio. As a result, the department scheduled an examination of ELIC to begin in October 1990 covering December 31, 1987, through December 31, 1990. In January 1991, the department increased its close monitoring of the company, requiring ELIC to retain consultants to review its asset portfolio, requiring it to submit a five-year business plan, and placing various restrictions on its activities.

In March 1991, the department's review of ELIC's 1990 annual statement showed that the market value of ELIC's bonds, as of December 31, 1990, was approximately $2.2 billion less than their reported statement value. On April 8, 1991, the department's chief of the financial analysis division confirmed in writing to the insurance commissioner that the independent accountants of First Executive Corporation did not express an opinion on the parent company's financial statements because of their substantial doubt about the parent company's ability to continue. Subsequently, on April 10, 1991, ELIC's president informed the insurance commissioner that ELIC may have been impaired as of March 31, 1991, because of a series of bond defaults and adjustments required by regulatory authorities. Finally, on May 10, 1991, the department finished its report of examination of ELIC showing a deficit in the company's surplus of approximately $356 million as of December 31, 1990. Part of the deficit was attributable to ELIC overvaluing its investments in bonds, stocks, real estate, and other assets by more than $461 million.

The department first had concerns about ELIC's investments as early as 1980. Even though the department repeatedly questioned ELIC's investments and investment practices in subsequent years, its regulatory efforts did not prevent ELIC's continued questionable investments, which finally resulted in the company overvaluing its assets by more than $461 million in 1991.

The Department Did Not Take Prompt and Decisive Action When It Detected Insurers' Improper Reinsurance Arrangements

During our review of a sample of 14 insolvent insurers, we found that improper reinsurance practices contributed to the insolvencies of 8 insurers. Like other companies, insurers purchase insurance for a variety of reasons, including the need to spread their risks and limit their exposure to large or catastrophic losses. Reinsurance is a form of insurance for an insurance company. Under a reinsurance contract, the primary insurer transfers or "cedes" to another insurer (the reinsurer) all or part of the financial risk of loss accepted in issuing insurance policies to the public. The reinsurer, for a premium, agrees to indemnify or reimburse the ceding company for all or part of the losses the latter may sustain from

claims it receives. Reinsurance may be obtained from professional reinsurers, reinsurance departments of primary insurance companies, reinsurance pools, and foreign reinsurers.

Reinsurance can cause problems for insurers if the reinsurer is either unwilling or unable to reimburse the primary insurer when necessary. In that event, the primary insurer would be liable for the claims arising from the business it had reinsured and for which it had reduced its loss reserves.

According to Section 922.4 of the California Insurance Code, for an insurer to reduce its estimated liability for losses associated with business ceded to a reinsurer (reinsurance credit) not admitted to conduct business in California (nonadmitted reinsurer), the primary insurer must prove certain things to the insurance commissioner. The primary insurer must show that the nonadmitted reinsurer meets the financial requirements and maintains the same standards as an insurer admitted to do business in this State. In lieu of demonstrating such proof, the code allows the primary insurer to withhold funds or obtain letters of credit from nonadmitted reinsurers in amounts equal to the estimated losses associated with the ceded insurance.

For seven of eight insolvent insurers whose insolvencies were caused, in whole or in part, by improper reinsurance, the department failed to ensure that the companies took prompt actions to correct reinsurance problems once they were detected. In the eighth insolvency, the department was unable to detect the problem. In the following pages, we describe an example of the department's lack of action. For a complete discussion of each of the companies we reviewed, see Appendix A.

Integrity Insurance Company

Integrity Insurance Company's (Integrity) state of domicile was New Jersey and, therefore, the New Jersey Department of Insurance would normally schedule all examinations of its financial condition. The California Department of Insurance placed Integrity

into conservatorship in January 1987 after New Jersey obtained an order of rehabilitation for the company. Before that action, the department was aware that Integrity had a history dating back to the late 1970s of noncooperation and failing to fully comply with the commitments it made to the department. Furthermore, as early as 1981, the department was aware Integrity had problems with reinsurance through its review of Integrity's annual statement. However, the department did not take regulatory action until May 1986.

Specifically, between 1978 and 1979, the department had extensive correspondence with Integrity regarding the insurer's application for an amendment to its certificate of authority. The amendment was necessary for Integrity to market new lines of insurance in California. While reviewing Integrity's application, the department requested a variety of information about the insurer's financial condition. However, according to department files, Integrity repeatedly either ignored requests for information or failed to correct the information reported in its statements. Because of Integrity's continued failure to comply fully with the department's requests, the department fined the company $25,000 in 1979. The stipulation-and-waiver order stated that Integrity's past actions may indicate inadequate management control over the preparation of its annual statements and an absence of appreciation for complying with California's requirements and requests from the department and commissioner. However, in spite of the fine and the lack of compliance with the department's requests for information, the department issued the amended certificate.

In March 1981, after reviewing Integrity's 1979 annual statement, a department examiner noted that the company had reinsured with 22 additional reinsurers that were not admitted to transact insurance in California. Also, from 1983 through 1986, the NAIC reports analyzing key financial ratios computed from Integrity's annual statements indicated that Integrity had a substantial amount of unauthorized reinsurance and that a large amount of this unauthorized reinsurance was with reinsurers located outside the United States.

The NAIC's analyses from 1981 through 1986 also showed a consistently unusual result in Integrity's ratio for surplus aid to surplus. This ratio attempts to measure the beneficial effect on surplus caused by an insurer's use of reinsurance. According to the NAIC's interpretation, an unusual result for this ratio may indicate that the insurer's surplus is inadequate and might cause enough of an improvement in the results calculated for its other ratios to conceal important areas of concern. The NAIC advises a regulator to thoroughly analyze an insurer's reinsurance agreements to determine their legitimacy whenever the results of an insurer's ratio for surplus aid to surplus is unusual. Moreover, other than a summary of an examination report for the year ended December 31, 1975, and one examination report of the company covering the five years ended December 31, 1980, we could not find any evidence that the department received any information from Integrity's state of domicile, New Jersey, that might have aided in the department's monitoring effort.

During 1985, the insurance analyst, A.M. Best, lowered its quality rating of Integrity because a substantial portion of the company's business was placed with reinsurers not licensed in the United States or without an A.M. Best rating. In May 1986, the department instructed Integrity to voluntarily cease writing any new or renewal business in California except for two lines generating approximately $250,000 in monthly premiums. The department took this action, in part, because of doubts concerning the company's ability to collect approximately $52 million in reinsurance owed to Integrity by two financially troubled companies. In July 1986, the department's review of Integrity's 1985 annual statement revealed that nine of the reinsurers Integrity dealt with were either in conservatorship, liquidation, or under cease-and-desist orders. The status of these reinsurers jeopardized the collectibility of $55.5 million in reinsurance owed to Integrity. The analysis also noted that Integrity did not secure a deposit or a letter of credit for a $4 million reinsurance credit the company claimed for a nonadmitted reinsurer. The analysis indicated that if this reinsurance credit and the $55.5 million was in jeopardy of collection, Integrity would have a deficit in its reported capital and surplus of $39 million. Therefore, the company would be

insolvent. Nevertheless, the department allowed Integrity to continue marketing the agreed two lines of insurance until September 1986. At that time, the department found that, in July 1986, Integrity had reported premiums of $1.6 million, far in excess of the agreed premium amount of $250,000 per month. As a result, the chief of the financial analysis division recommended the former commissioner issue a cease-and-desist order against Integrity. Before a formal order was initiated, however, Integrity agreed to voluntarily cease all business in California. The former commissioner finally applied for and received a court order appointing her conservator of Integrity in January 1987.

The department detected potential problems with Integrity's reinsurance as early as 1981. Further, the department knew that, dating back to the late 1970s, Integrity had a history of noncooperation and failing to comply with the commitments it made to the department. However, the department did not take any regulatory actions to correct the deficiencies noted in Integrity's reinsurance practices until May 1986 when the department instructed Integrity to voluntarily cease writing new or renewal business in California. Eight months later, the department received authority to conserve Integrity after determining the company was insolvent, in part, because of uncollectible reinsurance.

The Department Did Not Take Prompt and Decisive Action When It Detected Insurers' Improper Affiliate Transactions

The California Insurance Code, commencing with Section 1215, entitled the Insurance Holding Company System Regulatory Act, is frequently referred to as the California Holding Company Act and covers requirements for insurers' affiliate transactions. Affiliate transactions are transactions occurring between an insurer and its parent, subsidiary, or affiliate. Sections 1215.1 to 1215.5 of the California Insurance Code require a domestic insurer belonging to an insurance holding company system to do the following:

- Limit the amount it may invest in a subsidiary without the approval of the insurance commissioner;

- Obtain prior approval from the insurance commissioner for an acquisition of another domestic insurer;

- Annually file a registration statement disclosing any changes it makes in its management and control of operations during the past year, and report material changes within 15 days after the end of the month in which they occur;

- Report specified material transactions occurring within the past 12 months; and

- Obtain prior approval from the insurance commissioner for specified extraordinary transactions.

Further, Sections 1215.9 to 1215.12 of the California Insurance Code provide for the types of enforcement actions the commissioner may take against an insurer who violates the code sections dealing with the California Holding Company Act. These actions include injunction, criminal prosecution, seizure of business, or suspension or revocation of the license or authority to do business in this State.

Improper affiliate transactions can cause problems for an insurer if the purpose of those transactions is to remove the liquid assets of an insurance company for the benefit of its parent company or its affiliates. During our review of a sample of 14 insolvent insurers, we found improper affiliate transactions contributed to 7 of the insolvencies. For these 7 insolvent insurers, the department failed to take prompt and decisive actions even though it had for some time detected problems involving affiliate transactions. In the following pages, we describe an example of the department's lack of action. For a complete discussion of each of the companies we reviewed, see Appendix A.

Pacific Standard Life Insurance Company

The former commissioner was appointed by the court as conservator of Pacific Standard Life Insurance Company (Pacific Standard) in December 1989. The department had concerns about Pacific Standard's affiliate transactions as early as 1983. Specifically, in a 1983 letter written to a department examiner

summarizing past problems with Pacific Standard, another examiner expressed the belief that to circumvent California's investment limitations, the company transferred title to real estate acquired from one affiliate to other affiliates, partnerships, and joint ventures in exchange for mortgage loans. These mortgage loans were not subject to the real estate investment limitations found in California law and were, therefore, allowable as admitted assets. However, many of these mortgage loans provided no income to Pacific Standard in the form of interest payments or reductions in principal, indicating that these assets were nonperforming and might have been in default.

In 1985, the department again noted concerns regarding Pacific Standard's affiliate transactions. A department examiner recommended denying a request from Pacific Standard for the company to be exempted from the reporting requirements under California's Holding Company Act. Among her reasons, the examiner cited that, during 1983 and 1984, Pacific Standard completed 20 affiliate transactions totaling more than $65 million, many of which appeared questionable. For example, Pacific Standard paid out dividends in the same year it borrowed a significant amount from an affiliate although, to the examiner, such a transaction did not make good business sense. Specifically, Pacific Standard paid a $1.3 million dividend the same year it borrowed $8.4 million from an affiliate. The department agreed with the examiner and denied Pacific Standard's request.

The department again addressed the issue of affiliate transactions in a letter to Pacific Standard in January 1987. In that letter, the chief of the financial analysis division informed the company it had entered into affiliate transactions requiring the prior approval of the commissioner, and it had failed to obtain such approval in violation of the California Insurance Code. Pacific Standard responded to the department's letter stating that its legal counsel was reviewing the appropriate code section regarding the need for prior approval of affiliate transactions to determine if the company had failed to comply with California law.

Although a department examiner indicated in February 1987 that she would wait awhile and then follow up on Pacific Standard's violations of the California Holding Company Act, we found that the department did not make any more inquiries until November 1987. At that time, the department again wrote to Pacific Standard and reiterated the requirements regarding affiliate transactions and requested information regarding any such transactions that may have taken place after December 1986. More than seven months later, in June 1988, Pacific Standard finally responded, stating that the company was aware of the requirements relating to affiliate transactions and that it was complying with the law. However, after receiving one of Pacific Standard's filings disclosing affiliate transactions it completed between September 1987 and February 1988, one of the department's legal counsels expressed concern that, although most of the transactions required reporting or prior approval, Pacific Standard either did not report the transactions or failed to seek the department's prior approval. Furthermore, the legal counsel stated in an internal memorandum that the department's lack of action regarding Pacific Standard's affiliate transactions may have encouraged the company to act as if there were no regulatory requirements. Finally, the counsel requested that the financial analysis division review the filing and determine if regulatory action should be taken.

After reviewing Pacific Standard's filing of affiliate transactions in August 1988, an examiner from the financial analysis division concluded that all the company's affiliate transactions since January 1987 were willful violations of the law. Further, the examiner concluded that such actions threatened the financial condition of Pacific Standard and posed a hazard to its policyholders. It appeared to the examiner that Pacific Standard was acting like a bank for its affiliates because many of the transactions were for the purpose of transferring cash from Pacific Standard to its affiliates in exchange for illiquid assets such as mortgage loans. In addition, the examiner noted that most of the affiliate transactions appeared to be mere accommodations to affiliates and not the usual investment transactions found in the ordinary course of business.

Furthermore, the examiner stated that, as of December 31, 1987, Pacific Standard had investments in affiliates amounting to more than $95 million but had reported less than half that amount in its annual statements. Also, Pacific Standard had made additional investments in affiliates in early 1988 totaling almost $22 million that, when added to the 1987 balance in affiliate transactions, was more than three times the amount of the policyholders' surplus reported for 1987. Finally, the examiner recommended that the department take regulatory action against Pacific Standard for violating the law and also recommended initiating a special examination to determine whether Pacific Standard's various investments in affiliates were admissable as assets. The department's legal counsel, after reviewing the examiner's conclusions, also recommended that Pacific Standard be examined. However, the counsel deferred to the chief of the financial analysis division what, if any, action to take.

Despite these reviews and recommendations, the department did not take any regulatory action or schedule Pacific Standard for a field examination until May 1989, more than nine months later. In the interim, a department examiner reviewed Pacific Standard's quarterly statement as of September 1988 and noted the company had increased its affiliate transactions. Specifically, the examiner found that, between February 1, 1988, and September 30, 1988, Pacific Standard had acquired more than $97 million in assets from its affiliates. The bulk of these transactions were purchases by Pacific Standard from Southmark Corporation, its parent company, and other affiliates. The purchases were nonliquid real estate related assets such as mortgage loans, real estate, real estate partnership interests, and loans to affiliates collateralized by vacation time-share contracts. These transactions had the effect of removing cash from Pacific Standard and transferring it to Southmark and other affiliates. The department examiner concluded that Southmark was desperately in need of Pacific Standard's liquid assets because the parent company was suffering from severe cash flow problems and other financial crises.

The department filed its field examination of Pacific Standard in February 1990 covering the three years ended January 1, 1989. The results of the examination confirmed that Pacific Standard was insolvent and had acquired many overvalued and worthless assets from its affiliates. Examples of these assets included mortgage loans already in default; mortgage loans secured with second, third, or even fourth liens; nonperforming collateral loans; investments in the preferred stocks of the parent company, which had filed bankruptcy; and illiquid investments in stocks and partnerships not publicly traded and, therefore, with no ready market. Ultimately, department examiners found more than $79 million in overvalued real estate and stocks. The majority of these assets were the result of improper transactions between Pacific Standard and its affiliates. The former commissioner was appointed by the court as conservator of Pacific Standard in December 1989.

The department is currently pursuing a civil lawsuit against the former officers and directors of Pacific Standard alleging breach of fiduciary duty, conspiracy, and the looting and waste of corporate assets. The department is seeking damages in excess of $12 million.

The department had concerns about Pacific Standard's affiliate transactions as early as 1983. In subsequent years, the department failed to take any regulatory action despite the fact that Pacific Standard repeatedly and willfully violated the California Holding Company Act with its affiliate transactions. Seven years later, in 1990, the department's examiners declared Pacific Standard insolvent mainly because of its acquisition of more than $79 million worth of overvalued and worthless assets, the majority of which were acquired from affiliates.

The Department Did Not Take Prompt and Decisive Action When It Detected Insurers' Loss Reserve Deficiencies

Section 923.5 of the California Insurance Code requires each insurer transacting business in California, at all times, to maintain reserves in an amount estimated in the aggregate to provide for payment of all losses and claims for which the insurer may be liable and to provide for the expense of adjustments or settlements of losses and claims. If the insurer does not do so, then it may not have the funds necessary to pay for policyholders' claims.

During our review of a sample of 14 insolvent insurers, we found that underreserving contributed to 10 of the insolvencies. For these 10 insolvent insurers, the department failed to take prompt and decisive actions in 9 cases even though it had for some time detected problems involving reserves. As for the tenth insolvency, the department was unable to detect the problem because of the manner in which insurers reported information at that time. In the following pages, we describe an example of the department's lack of action. For a complete discussion of each of the companies we reviewed, see Appendix A.

First California Property and Casualty Insurance Company

The former commissioner was appointed conservator of First California Property and Casualty (First California) in September 1989, and the company was liquidated in October 1989. Although the department was aware of First California's problem with its reserves for more than two years, it did not take all available regulatory measures to ensure that First California corrected its reserve deficiencies. Loss reserves are funds insurers hold to pay for present and future losses from policyholders' claims. Loss adjustment expense reserves are funds insurers hold to cover the costs associated with adjusting and settling claims and losses. The amount an insurer holds in its reserves should be based upon the insurer's experience or, where experience is lacking, on reasonable actuarial analyses of the losses expected for the type of coverage the insurer writes.

In August 1987, the department completed its field examination of First California as of December 31, 1986. The examination revealed the company had a $1.4 million deficiency in its loss and loss adjustment expense reserves. Furthermore, First California's adjusted policyholders' surplus was $1,000,853. This surplus amount included a $1 million cash contribution First California's parent company made in 1986. Without the cash infusion, First California, as of December 31, 1986, would not have had the $1 million in surplus required by California law to be deemed statutorily solvent. Although we found the department requested a meeting with First California officials in September 1987 to discuss the company's financial condition, we could not find any evidence that the meeting took place. However, according to the chief of financial surveillance, who was at that time chief of the financial analysis division, the meeting did take place during the fourth quarter of 1987. According to the chief, the meeting was attended by himself, a former chief deputy commissioner, and First California's president. The items discussed included First California's financial problems and the company's need for a capital infusion as well as problems relating to one of the company's managing general agents.

In February 1988, the department approved the acquisition of First California by the president of two other insurance companies located in Oklahoma and Colorado. The purchaser agreed to infuse $1.5 million into First California, an amount necessary to ensure the immediate survival of the company. In March 1988, the NAIC's analysis of key financial ratios confirmed First California was seriously underreserved for its losses as of December 31, 1987, and recommended that the department accord the company immediate regulatory attention. In the same month, the department completed a market conduct examination covering 1987 that also found First California was underreserved in both its personal and commercial lines. The purpose of a market conduct examination is to evaluate an insurer's compliance with requirements in the California Insurance Code regarding selling, advertising, underwriting, rating, and claims servicing.

Although the department and First California's new chief executive officer (CEO) corresponded regularly during 1988 concerning ways to infuse additional capital into First California, in June 1988, the department still placed First California on its internal watchlist as a company showing signs of potentially serious problems.

In May 1989, department representatives met with First California's CEO to discuss various discrepancies noted in the company's 1988 annual statement. Among those items discussed were the steps First California was taking to strengthen a $2.1 million deficiency in its loss reserves reported as of December 1988. Finally, in June, the financial analysis division requested a special field examination of First California identifying as problem areas asset valuations, affiliate transactions, losses, and the insurer's solvency. Department examiners completed their special examination in October 1989, determining that First California had deficiencies in both its loss and loss adjustment expense reserves amounting to $1.8 million as of June 30, 1989. The department also concluded that First California was insolvent by approximately $7 million as of the same date.

Since becoming the liquidator for First California, the commissioner has applied to the court for approval to retain counsel. If the court approves, counsel will investigate alleged violations of the California Insurance Code and other laws in connection with the operation of First California. Counsel will also determine what, if any, claims exist against the company's officers, directors, and affiliates. In addition, Colorado's deputy commissioner filed suit against First California's CEO, who was also the president of a Colorado insurance company. The suit alleges that the CEO, in his capacity as president of the Colorado insurer, converted assets for his own use and committed fraud. The suit seeks $400,000 plus interest and court costs.

The department detected shortages in First California's reserves as early as 1987. Thereafter, the department did not take any formal actions to ensure First California corrected the problem. Two years later, shortages in First California's loss and loss adjustment expense reserves made up more than $1.8 million of the company's nearly $7 million insolvency.

The Department Did Not Take Prompt and Decisive Action When It Detected Insurers' Poor Underwriting Problems

During our review of a sample of 14 insolvent insurers, we found that underwriting problems contributed to 2 of the insolvencies. For these 2 insolvent insurers, the department failed to take prompt and decisive actions even though it had for some time detected problems involving underwriting.

Underwriting is the process of selecting risks for insurance and determining in what amounts and on what terms the insurer will accept the risks. Underwriting problems occur when an insurer charges premiums that do not generate sufficient income to pay for the losses sustained by its policyholders. For example, to gain advantage over its competition, an insurance company may deeply discount its premiums for a particular line of insurance, thus generating a substantial amount of income in the near term. However, when policyholders sustain the losses associated with those policies, the magnitude of the losses will exceed the amount collected in the form of premiums, thus draining an insurer's surplus. In the following pages, we describe an example of the department's lack of action concerning underwriting. For a complete discussion of each of the companies we reviewed, see Appendix A.

Coastal Insurance Company

The department was given authority to place Coastal Insurance Company (Coastal) into conservatorship in February 1989. Coastal was a wholly owned subsidiary of Advent Management Corporation (AMC). AMC, in turn, was owned by Advent Company. AMC served as Coastal's managing general agent. Such agents perform a variety of insurance-related services including underwriting, premium financing, and claims reserving and adjusting. In October 1985, AMC acquired ownership of Public Insurance Services (Public). In January 1986, AMC, doing business as Public, began issuing automobile liability policies to high-risk drivers in Coastal's name. These developments were significant because not only was Coastal changing the way it underwrote its insurance products, but it was also providing its insurance products to a new high-risk market. It can be hazardous

when an insurer changes the way it markets its products or changes the group it markets its products to. One danger is that the insurer will suddenly increase its underwriting volume without a sufficient amount of surplus to protect against the increase in losses associated with the increase in business written. The other danger is that the insurance premiums charged may not reflect the new types of risks being underwritten. The fact that this change in Coastal's underwriting concerned the department became evident in a memorandum written in April 1986 by an examiner from the financial analysis division. The examiner requested that Coastal's field examination date be moved up as a result of the company underwriting a significant amount of new auto liability business through Public, acting as its agent. However, the field examination of Coastal did not begin until April 1987, a year later.

An examination report for Coastal was completed in July 1987 covering the three years ended December 31, 1986. In a section of the report commenting on events occurring after this three-year period, the department's examiners noted that, during the first two months of 1987, Coastal's affiliates acquired two insurance agencies. The examiners concluded that, during 1987, Coastal had shifted away from using independent agents to become a direct underwriter through Public and its two new affiliates, FGS Insurance Agency (FGS) and Warschaw Insurance Agency (Warschaw). In October 1987, an examiner from the financial analysis division noticed that Coastal's automobile casualty business had increased and that the casualty operations seemed marginal. The examiner recommended closely watching any developments from Coastal's casualty business.

In March and April 1988, the department performed a market conduct examination of Coastal to investigate complaints involving the insurer's handling of insurance claims. During a market conduct examination, examiners may inspect the insurer's claim documents and processing procedures to ensure that the insurer fulfills its lawful obligations to policyholders filing claims. The examination was prompted by a 287 percent increase in the number of complaints the department received in 1987 involving Coastal. The results of the market conduct examination revealed pervasive

shortcomings in Coastal's ability to handle its auto claims properly. The department's examiners sampled 462 automobile claim files and found errors in 185 for an overall error rate of 40 percent. Examiners cited problems including delays in the processing and payment of claims, insufficient documentation in claim files, and inadequate reserving. The department instructed Coastal to submit, within 15 days, a written response outlining its planned corrective action to address the examiners' findings. Examiners also informed Coastal that, because of the high error rate, the department would conduct a follow-up examination in six months. Finally, the department warned Coastal that, unless significant improvements were found at that time, the department would proceed with more formal actions authorized by law.

Also, in April 1988, the department, in conjunction with the market conduct examination, performed an underwriting examination of Coastal. Some of the factors the examination criticized Coastal for were its failure to provide adequate service to clients, its failure to provide the department with prompt and fully responsive answers to inquiries, its failure to exercise reasonable control over one of its general agents, and its failure to make full disclosures in its dealings with its clients. The examiners concluded that, among insurers marketing personal automobile lines of coverage, Coastal ranked in the lowest 7 percent for 1987. In addition, over two years, Coastal had experienced an increase in complaints, and the trend appeared to be worsening. As in the market conduct examination, the department instructed Coastal to respond to the findings included in the report within 15 days. However, the department failed to pursue any formal regulatory action against Coastal even though the two examinations' results should have been sufficient warning to the department about the precarious nature of Coastal's claims practices and financial condition.

In September 1988, after reviewing Coastal's June quarterly statement, one of the department's examiners found Coastal had a $9 million deficiency in its loss reserve and was writing premiums at an annualized volume of seven times its surplus, a volume considered unacceptable. Both the NAIC and the department use

the benchmark of three as the definition of a prudent ratio of premiums written to surplus. If an insurer exceeds this benchmark, its surplus may not be sufficient to absorb above average losses associated with the premiums it is writing. In his letter to Coastal's president, the examiner stated that the department was very concerned about Coastal's financial stability and believed a $10 million cash infusion was imperative to avoid further regulatory action.

In October 1988, the department performed a follow-up to the market conduct examination completed in April. The department's examiners found the same problems as those cited in the first market conduct examination. Moreover, the department's examiners concluded that the overall quality of Coastal's claim handling had deteriorated since the first examination. Further, in November 1988, one of the department's examiners advised the legal division to deny a pending application from Coastal to underwrite additional lines of insurance or to request Coastal to withdraw the pending application. The examiner cited among his reasons for denial the fact that Coastal had claims and underwriting problems and was overextended in its underwriting capacity.

In December 1988, the department began another examination of Coastal's rating and underwriting practices. However, the department never completed it. According to an unfinished draft report, the department found that Coastal did not always use established underwriting guidelines. For instance, the examiners found that for a Mexican trucking line of business, the agent set the insurance rates solely through judgment. In addition, the department's examiners could not conduct the usual study of the loss and expense experiences for the previous three years because neither Coastal nor the department was able to locate important data necessary for the study.

In February 1989, the department completed a special field examination of Coastal. The department's examiners noted that the amount of premiums Coastal earned had grown from approximately $9 million in 1986 to approximately $85 million by September 30, 1988. Moreover, during the nine months ending

September 1988, Coastal sustained a net underwriting loss of approximately $26 million. Subsequently, the department concluded through its examination that Coastal was insolvent by approximately $47 million.

After the department issued a conservatorship order in February 1989, it formed a task force to investigate the circumstances behind Coastal's insolvency. The task force ultimately determined that Coastal did not use any underwriting guidelines. This failure to use guidelines contributed to Coastal's underwriting losses. Specifically, the department found that, from January 1986 through December 1988, Coastal had increased its share of the substandard automobile liability market in California through drastic and rapid growth. Coastal's premiums increased from approximately $13 million to approximately $144 million during those three years, with approximately $113 million in premiums written in 1988 alone. During those same three years, Coastal suffered major underwriting losses. For example, during 1987, Coastal reported a net underwriting loss of approximately $46 million. In addition, from January to September 1988, Coastal sustained another net underwriting loss of approximately $26 million.

The department is currently pursuing a civil lawsuit against the former officers and directors of Coastal for numerous violations of the California Insurance Code and federal laws. In the lawsuit, the department contends that Coastal ignored and circumvented recognized underwriting principles, sales practices, and the requirements of California laws for the prudent management of an automobile liability insurance business. The department found that Coastal disregarded basic underwriting standards by falsifying customer applications so that lower premiums could be charged, thereby, enabling applicants to qualify for insurance.

Despite negative information from financial reviews in April 1986, a field examination completed in July 1987, two market conduct examinations in April and October 1988, and an underwriting examination in May 1988, the department allowed Coastal to continue operating until February 1989, thereby,

endangering more policyholders and allowing the financial condition of Coastal to further deteriorate. However, the department did not take any formal regulatory action against Coastal. Because of Coastal's poor underwriting practices, the company sustained an underwriting loss of approximately $26 million. This loss contributed to its insolvency of approximately $47 million.

The Department Did Not Take Prompt and Decisive Action When It Detected Insurers' Poor Use of Managing General Agents

During our review of a sample of 14 insolvent insurers, we found that poor use of managing general agents contributed to 4 of the insolvencies. A managing general agent is an individual who manages all or part of the insurance business for an insurer, underwrites premiums, and adjusts or pays claims. Insurers typically compensate their agents by paying commissions based on the amount of business they write. Since managing general agents are not generally responsible for the claims that will eventually need to be paid, these commission arrangements place insurers in a potentially precarious position. Agents have the freedom and incentive to bind the insurers they work for to large quantities of coverage without necessarily being responsible for the quality of that coverage.

Managing general agents may also negotiate reinsurance contracts on behalf of insurers they work for. By ceding most of an insurer's risk to reinsurers, agents effectively enable the company they work for to write more business since ceding reinsurance risks allows the company to reduce its loss reserves associated with those risks. When the company is able to write more business, the agents can profit by earning more in commissions. Because of these arrangements, it is necessary for insurers to closely monitor the activity of their agents, to determine the types of risks being covered, and to determine the quality of the reinsurance being arranged.

For the four insolvent insurers for which managing general agents were a key cause of insolvency, the department failed to take prompt and decisive actions in three cases even though it had for some time detected problems involving managing general agents. In the fourth insolvency, the department was unable to detect the problem early enough to intervene in any meaningful way. In the following pages, we describe an example of the department's lack of action. For a complete discussion of each of the companies we reviewed, see Appendix A.

Ideal Mutual Insurance Company

The department issued a cease-and-desist order against Ideal Mutual Insurance Company (Ideal) in December 1984 and was given authority to conserve the company in January 1985. Because Ideal was domiciled in New York, the New York Insurance Department scheduled all field examinations of Ideal. In June 1980, the department received New York's field examination report of Ideal covering the three years ended December 31, 1977. New York's examiners found that Ideal wrote aviation insurance through a managing general agent and, then, ceded 95 percent of the risk principally to unauthorized reinsurers located outside the United States. Further, the New York examiners also reported that Ideal was engaged in another underwriting program designed to service unauthorized reinsurers located outside the United States. Under this program, Ideal wrote policies for risks within the United States and, subsequently, would cede substantially all of the risk to an unauthorized reinsurer located in Bermuda. These two underwriting programs represented almost 27 percent of the total premiums written by Ideal in 1977, and according to the examiners, both appeared to be fronting arrangements considered illegal by the New York Insurance Department.

Fronting arrangements allow companies not licensed to transact insurance business within a given state the ability to transact that business without regulatory oversight. Fronting is made possible when a licensed company, such as Ideal or its managing general agent, underwrites business in its own name and, then, cedes

substantially all the risk associated with that business to an unlicensed company for a fee. The examiners concluded that, as of July 1979, the New York department was still reviewing the issue of fronting by Ideal, and no final regulatory decision would be made at that time. We could find no documentation that the California department contacted either the New York department or Ideal to determine what the resolution was concerning the fronting arrangements.

The California department, though not the domicile state for Ideal, still received annual copies of Ideal's financial statements and the NAIC's analyses of Ideal's financial ratios. In fact, in 1981 and 1982, the NAIC reported that several of Ideal's financial ratios were outside of industry norms. These ratios indicated possible deficiencies in loss reserves, inadequate liquid assets to meet financial demands, and disproportionately high balances for agents. As a result, in 1981 and again in 1982, the NAIC recommended that Ideal be given immediate regulatory attention. However, although Ideal appeared on the department's watchlist during 1982 and 1983, indicating more intensive scrutiny should be given, we could find no evidence that the department increased its monitoring effort regarding Ideal at that time. To the contrary, we found no record that the department had completed any financial reviews of Ideal's statements between 1977 and 1983.

According to an internal department document, by August 1983, the department had received a preliminary draft of New York's examination of Ideal as of December 1980. The New York examiners had initially found Ideal to be insolvent by approximately $7.4 million. The amount was later revised in the final report to an insolvency of $6.5 million. The California department used this information in denying Ideal's application for an amended certificate of authority to transact additional insurance business in California. The application was already pending, and the department took no further regulatory action at that time. The amended certificate of authority would have allowed Ideal to write additional lines of insurance business in California.

In March 1984, the department received the final version of New York's field examination report of Ideal covering the three years ended December 31, 1980. The examiners reported that, as of December 31, 1980, Ideal was insolvent primarily because Ideal had underreported its liability for unauthorized reinsurance by approximately $23 million. A significant portion of the liability represented reinsurance placed with an affiliate, Optimum Insurance Company of Illinois, a wholly owned affiliate of Optimum Holding Company. Optimum Holding Company, a subsidiary of Ideal, was formed to act as Ideal's managing general agent. Although the department did not receive the finalized version of the field examination report from the New York Insurance Department until 1984, the department had its own examiner participating in the examination and, thus, should have had some knowledge of Ideal's financial condition during the course of the examination.

After reviewing Ideal's September 1984 quarterly financial statements, one of California's examiners wrote to the company's president in November 1984 concerning Ideal's deteriorating financial condition. The examiner warned that Ideal's surplus had fallen by 28 percent and was insufficient to support the volume of premiums being written. In addition, the examiner requested that Ideal either voluntarily cease writing business in California immediately or infuse additional funding to increase the amount of its surplus. The letter also requested a response within three weeks, but we could find no such response.

In December 1984, the department received another field examination report of Ideal from New York covering the three years ended December 1983. The examination found Ideal to be insolvent by more than $155 million. The examination indicated that Ideal underreported its liability for unauthorized reinsurance by approximately $120 million. Again, as was reported in the 1980 field examination, a significant portion of the liability represented reinsurance placed with Optimum Insurance Company of Illinois, a subsidiary of Ideal's managing general agent. California issued a cease-and-desist order against Ideal days after New York placed it in rehabilitation.

As early as 1980, the department found that Ideal made questionable use of managing general agents to develop its business and to reinsure business with third party reinsurers. Although Ideal's financial condition continued to deteriorate, based upon our review, the department took no formal regulatory action requiring Ideal to control its managing general agents until more than four years later, in December 1984. At this time, the department issued a cease-and-desist order against the company in California when the New York examiners found Ideal to be insolvent by more than $155 million. Approximately $120 million of this amount was the result of unauthorized reinsurance, and the majority of the reinsurance was placed with a wholly owned subsidiary of Ideal's managing general agent.

The Department Did Not Take Prompt and Decisive Action When It Detected Agents' High Balances

During our review of a sample of 14 insolvent insurers, we found that agents' high balances contributed to 2 of the insolvencies. An insurer establishes agents' balances to recognize amounts its agents owe to the company for premiums collected on the company's behalf. Normally, the agents remit these premiums to the company regularly, usually monthly. Agents' high balances that are long outstanding in relation to an insurer's surplus are of concern because they are a measurement of the degree to which solvency depends on an asset that frequently is not collectible in the event of the insurer's liquidation. For the 2 insolvent insurers for which we determined that agents' high balances were a key cause of insolvency, the department failed to take prompt and decisive actions even when it had for some time detected the key cause. In the following pages, we describe an example of the department's lack of action regarding agents' high balances. For a complete discussion of each of the companies we reviewed, see Appendix A.

Cadillac Insurance Company

The department issued a cease-and-desist order against Cadillac Insurance Company (Cadillac) in April 1989 and received authority to conserve the company in January 1990. Cadillac was domiciled in Michigan and conserved in that state in July 1989. As

early as 1985, the department found that, in a review of Cadillac's 1985 quarterly statements, Cadillac had written more direct premiums in the first six months of 1985 than it had in the entire previous year, indicating that it was rapidly expanding its business. Direct premiums are premiums relating to the business an insurer writes itself, as opposed to premiums for business an agent writes. In addition, by September 1985, Cadillac's reported agents' balance was higher than the NAIC considers normal for the industry in relation to its surplus. An insurer's surplus is the amount by which the assets of the insurer exceed its liabilities less capital. According to the NAIC's interpretation, the ratio of agents' balance to surplus measures the degree to which an insurer's solvency depends on an asset that frequently cannot be converted to cash. The ratio is reasonably effective in distinguishing a troubled company from a sound one. Because the company had written so many direct premiums and because of the agents' high balance, the department examiner noted that Cadillac had failed his summary analysis for 1985 and recommended that the company be placed on the department's watchlist.

In July 1986, after reviewing Cadillac's quarterly financial statement, the department examiner found that Cadillac continued to rapidly expand the volume of premiums it was writing and still exhibited a high balance for agents in relation to its surplus. The department examiner was also skeptical of the company's ability to properly prepare its financial statements and recommended that Cadillac be required to limit the amount of its net written premiums to no more than was written in 1985. The chief of the department's financial analysis division discussed some of the department's concerns with Cadillac's president. The chief advised the president that the department would review Cadillac's June 1986 quarterly statement and would probably restrict the amount of premiums Cadillac could write in California if the department continued to have concerns regarding Cadillac. After a review of Cadillac's June 1986 quarterly statement, the examiner concluded that the earlier discussions had failed to curb the amount of premiums Cadillac was writing. The examiner noted that the ratios of net written premiums and agents' balance to surplus were considered to be hazardous to Cadillac's financial condition and recommended that the company be upgraded from the "watch" category to the

"special reporting" category. However, the examiner's supervisor instructed him to change the regulatory status of Cadillac to "monthly reporting." According to the department's watchlist categories, a "watch" company shows signs of having potentially serious problems. A "special reporting" company is required to provide periodic reports or correspondence to the department. A "monthly reporting" company must file financial statements with the department each month.

In September 1986, the department sent a letter to Cadillac's president requesting that the company curtail its premium writings in California and requiring that the company file monthly financial statements with the department. The letter further warned that, if Cadillac failed to curtail its writings in California, the department would issue a cease-and-desist order against Cadillac. Shortly thereafter, according to a letter written to the department from Cadillac's president, Cadillac's parent company, Arlans Agency, Inc., contributed $2 million in cash to Cadillac's surplus so as to improve its ratios, and the department subsequently dropped its request that Cadillac curtail its writings in California. However, the department did continue to require monthly statements from Cadillac.

During 1987 and 1988, both the department's review and the NAIC's reports of key financial ratios found that Cadillac continued to have a high balance for agents in relationship to its surplus. In June 1988, a supervising insurance examiner in the department's financial analysis division sent a letter to Cadillac's president requesting him to voluntarily cease writing any new business in California. Among the department's reasons for this action, the examiner cited Cadillac's balance for agents in relation to Cadillac's surplus, a deteriorating liquidity position, loans to officers that the Insurance Code prohibits, and improper affiliate transactions. In September 1988, Cadillac's president agreed to restrict the volume of premiums in California to no more than was written in 1987 and to diligently work toward reducing the agents' balance. At that time, the president was also aware that the department was considering a special examination of Cadillac to begin around March 1989.

In March 1989, the NAIC's report of key financial ratios computed from Cadillac's 1988 annual statement indicated that the company still had a high balance for agents in relationship to its surplus. Furthermore, at the end of March, the department's chief examiner of the field examination division informed the former commissioner that a financial examination in progress at Cadillac revealed the company was either statutorily impaired or insolvent. Statutory impairment occurs when the assets of an insurer are less than the sum of the insurer's required minimum capital and surplus and all its liabilities. In April 1989, the department issued a cease-and-desist order against Cadillac requiring the insurer to immediately discontinue writing any new or renewal business in California except such renewal business as may be mandated by contract. In January 1990, the former California insurance commissioner petitioned the court to become the conservator of Cadillac.

According to the Michigan Insurance Bureau's complaint for conservatorship, as of March 31, 1989, Cadillac was insolvent by approximately $18 million, and the unpaid agents' balance owed by Cadillac's parent company, which was also Cadillac's agent, totaled approximately $17 million.

As early as May 1985, the department found that Cadillac's reported agents' balance was higher than the NAIC considers normal for the industry. Despite a continued pattern of excessively high balances for agents during the next four years, noted by both the NAIC and the department's own analyses, the department did not take any effective action to require Cadillac to correct the problem.

Corrective Action

The department has established two new positions, chief of enforcement and chief of financial surveillance. These positions will report directly to the chief deputy commissioner and become members of the commissioner's executive staff. With the creation of these positions, the department also reorganized its regulatory functions. The chief of financial surveillance oversees the financial

analysis division, the field examination division, and the actuarial division. The chief of enforcement oversees the conservation and liquidation division, licensing/investigation/fraud division, and the legal division.

In addition, the department has a number of bills pending before the Legislature. These bills address such issues as enabling the commissioner to prohibit certain individuals from participating in the insurance business, requiring life and health insurers to submit actuarial certifications of reserves, regulating reinsurance intermediaries, regulating managing general agents, and placing limitations on insurers' investments in junk bonds, real estate, and other investments. Since the department submitted its proposed corrective actions, some of the pending legislation has become law. For example, the pending bills to regulate reinsurance intermediaries and managing general agents have both become law. However, as discussed in the introduction, unlike the NAIC's versions of these two acts, the versions California adopted do not require managing general agents or reinsurance intermediaries who violate the respective laws to make restitution.

The department has also formed troubled-company teams to monitor targeted troubled companies. These teams are composed of financial analysts, field examiners, attorneys, actuaries, and, when necessary, outside consultants. The department is currently studying the team approach to determine if such teams should be formalized and permanently instituted. Further, the department has held meetings among its various divisions to identify all data available that would be helpful in the surveillance of insurers. These meetings will form the basis of an interdivisional network within the department.

The financial analysis division now has computer access to all the financial data available from the NAIC. The available data includes information from the last five years of insurers' annual filings with the NAIC. The financial analysis division has also begun the installation of an integrated database that will include a number of surveillance tracking systems. Additionally, the division has completely revised its *Standards Procedures Manual*

and will continue to update the manual as needed. Finally, the division increased its staffing by 14 professional positions beginning in fiscal year 1991-1992. The division also plans to augment its reinsurance bureau by adding two staff to the existing two it now has.

The department is considering purchasing software to test the cash flow capabilities of various life insurance products and their effects on insurers' profitability. The department thinks this type of testing will be useful for monitoring life insurers such as the Executive Life Insurance Company, which sells interest-sensitive products like guaranteed annuities.

Lastly, the department has been gathering data from property and casualty insurers to analyze the benefits of requiring insurers to maintain capital levels based on the types of risks they insure.

Because the department took all these corrective actions after or shortly before the end of our fieldwork, we had no opportunity to determine how successful they may be in improving the department's surveillance and regulation of insurers.

Conclusion

In all but one of the cases we reviewed, the department was able to identify and detect the problem areas that led to the insolvencies of the failed insurers we reviewed. However, the department did not always take prompt and decisive regulatory action after it had discovered these problems. Instead, the department relied upon informal and time consuming discussions that ultimately failed to yield any appreciable results. For example, in the case of foreign insurers, the department waited until the domiciliary state had taken action before it took action itself.

In addition, as we cited in the examples throughout this chapter, there were numerous instances when the department put insurers on its watchlist but made no additional monitoring effort. Furthermore, although department examiners made recommendations calling for special or focused examinations and

even recommendations for the issuance of cease-and-desist orders, department management often failed to act on those recommendations.

Delaying prompt and effective regulatory action can increase the costs of insolvencies. First, if an insurer is allowed to continue writing new policies during the period in which the department tries to informally discuss corrective action, then more policyholders will be adversely affected if the insurer fails. Second, the financial condition of the problem insurer may continue to deteriorate during this interim period. In cases such as Pacific Standard, a delay allowed the parent company of the insurer to remove valuable assets from the company. The financial consequence of such an action is ultimately an increase in the financial cost of the insurer's insolvency. Third, the costs of the insolvencies are passed on to the policyholders of healthy companies in the form of higher insurance rates.

Another effect of insolvencies is that policyholders whose policies are not covered by a guarantee fund can lose their life savings. For these policyholders, the only hope of receiving even partial payment is to list themselves as unsecured general creditors. Unsecured general creditors have a lower priority in the distribution of a failed company's liquidated assets.

Recommendations

To improve the department's regulatory system and to ensure the department takes prompt and decisive action when it detects problems with an insurer, the department should take the following actions:

- Revise its method of investigating officers, directors, and major shareholders of insurers applying for new and amended certificates to include the use of periodic requests for information from other agencies, a unique identifying system for obtaining information from the Securities and Exchange Commission relating to specific individuals, and better documentation of the information obtained;

- Institute a more effective and assertive communication system with other state regulators;

- Develop clear criteria for each examiner to use in performing analyses of insurers' financial statements. The criteria should be linked to the watchlist the department currently uses and should indicate what symptoms an insurer must exhibit to be placed in each of the list's categories. The criteria should also indicate the level of surveillance to be accorded each category;

- Require analysts and examiners to document their reviews of insurers' financial statements and require management to justify those instances when a recommended action is not taken;

- Develop guidelines for creating corrective action plans. Each corrective action plan should specify a timeframe within which the insurer must correct the problems the department identifies. The plans should also include department follow-up measures and outlines of alternative actions the department will take if insurers do not meet the established timeframes; and

- Restructure field examinations to focus on known problems of the insurer, problems that have caused insolvencies in the past, or areas that can be easily misstated or misrepresented.

To improve the department's regulatory practices aimed at questionable investments, the department should pursue the following actions:

- Use the commissioner's broad regulatory authority to encompass risky investment practices, thus, enabling the commissioner to eliminate or remedy any investment practice that is considered hazardous to an insurer or its policyholders;

- As a guide for making prudent investment decisions, require each insurer's board of directors to annually develop written investment policies that address asset diversification, concentration risks, interest rate risks, liquidity, investments in affiliates, and any other appropriate investment issues; and

- Review each company's investments to ensure the insurer is adhering to its stated investment policies.

To improve the department's regulatory practices aimed at improper affiliate transactions, the Legislature should modify the California Holding Company Act, instituting substantial civil penalties for violations of the act.

To improve the department's regulatory practices aimed at loss reserve deficiencies, the department should require actuaries to test the reliability of an insurer's data as part of their certification of reserves.

To strengthen the department's regulatory authority aimed at improper reinsurance and poor use of managing general agents, the Legislature should amend the California Insurance Code to include the sections of the NAIC model laws that would require reinsurance intermediaries or managing general agents that violate the law to make restitution to an insurer for any losses they cause.

To improve the department's regulatory practices concerning poor underwriting, the department should use the consumer complaint data it receives as well as any unusual or negative trends developing in an insurer's premium volume or product mix in prioritizing the companies scheduled for field rating and underwriting examinations. These examinations should include sampling the various types of policies the insurer writes to determine if the insurer is using the appropriate underwriting guidelines and charging the proper rates. For insurers demonstrating underwriting problems, the department should develop and use corrective action plans similar to the ones previously recommended.

To improve the department's regulatory practices aimed at agents' high balances, the department should actively enforce the provisions contained in the recently enacted law pertaining to managing general agents. One provision of this law requires the monthly remittance of funds owed to the insurer.

Chapter 2 The Department Should Improve Its Coordination With the Regulators of Other States and National Agencies

Chapter Summary

During our review, we found that communication among state regulators is poor and ineffective. In general, state regulators were reluctant to share information about financially troubled insurers. Furthermore, when other states do share information, it is often so outdated that it is of little value. According to a United States General Accounting Office (GAO) survey conducted between April 1987 and January 1989, only 15 states would fully share information with other states and provide regular updates on a financially troubled insurer. Some state regulators said they were concerned that if other states learned about a problem insurer, they might suspend the insurer's license, thus, making the situation public and increasing the chances of insolvency.

We also found that the California Department of Insurance (department) did not diligently pursue information that could have shed more light on the financial problems leading to the insolvencies of five insurers we examined that were incorporated in other states. In most instances, the California department opted to wait and let the domiciliary state take action rather than take action itself. A domiciliary state is the state in which an insurer is incorporated or organized.

Further, as part of its regulatory responsibilities, the department screens entrants applying to transact insurance business in California. This screening includes a background investigation of all officers, directors, and major stockholders of an insurer when the insurer applies for a new or amended certificate authorizing it to transact business in California. In

conducting these background investigations, the department contacts other agencies such as the Securities and Exchange Commission (SEC) and the National Association of Insurance Commissioners (NAIC) and requests information on whether these individuals have had any regulatory or disciplinary action taken against them.

We found that the coordination between the department and national agencies is ineffective because the department's system of contacting these agencies has several flaws. For instance, the department does not coordinate with the SEC in using a unique identifying system to identify the individuals the department is trying to screen. The lack of a unique system sometimes results in the department receiving adverse information on a person and not being certain that the information applies to the person the department is screening. In these situations, the department asks the person being screened if the adverse information applies to them and attempts to gather other information to verify that the applicant is, in fact, the same person. Finally, the department either does not always contact the agencies as it should or does not adequately document the information it receives from these agencies.

Without an effective system of cooperation and communication among state regulators and national agencies, appropriate regulatory action regarding financially troubled insurers is frequently delayed, unnecessarily exposing policyholders and others to harm.

Communication and Cooperation Among State Regulators Is Poor

While the department is responsible for regulating all insurers licensed to conduct business in California, the examination of foreign insurers transacting insurance business in California is of particularly vital interest to the department since a majority of the insurance business in this state is transacted by such insurers. The examination of foreign insurers is essential because each state insurance commissioner's authority to regulate foreign as well as

domestic insurers serves to enhance the regulatory effectiveness of the domiciliary state. Thus, if the regulation of the domiciliary state fails for some reason, the other states are still able to ensure that financially troubled insurers correct identified problems so as to protect their policyholders from the harm insolvencies can cause.

Although the NAIC organizes multistate field examinations, called association examinations, for the purpose of allowing states other than the domiciliary state the opportunity to participate in examinations of foreign insurers, the primary responsibility for examining these insurers rests with the domiciliary states. While the California department can do much of its own monitoring and regulatory review in areas such as the financial analyses of the annual statements of the foreign insurers authorized to do business in California, the California department must rely upon the domiciliary states' regulators for information in other areas such as information from field examinations of foreign insurers.

Thus, to detect potential problems within insurance companies before policyholders and others suffer, state regulators must communicate with each other. For example, insurance regulators have found that the individuals causing the most problems within the industry and those usually connected with insurer insolvencies are those individuals who move from one state's jurisdiction to another as soon as an insurance department discovers or begins to question their operations. To control this trend of interstate abuse, state regulators must inform one another about these individuals.

States can communicate with each other and the NAIC about regulatory actions and suspect companies and individuals through a computer network the NAIC developed. Insurance departments located throughout the United States are all linked to this network through computer terminals the NAIC placed in each department in March 1988. Moreover, if the insurer's domiciliary state fails to act appropriately, then the NAIC can exert peer pressure on the domiciliary state or recommend that other states take action. Even if the domiciliary state is acting appropriately in regulating the troubled insurer, a special group of designated states can monitor the regulatory activities of the domiciliary state.

Therefore, effective communication among state regulators is now possible and is essential if all states are to be fully aware of an insurer's financial condition. However, according to a GAO report issued in September 1989, only a few states surveyed would fully share information with and provide regular updates to other states and the NAIC on a financially troubled insurer. Some state regulators told the GAO they were concerned that if other states learned about a problem insurer, they might suspend the insurer's license, thus making the situation public and increasing the chances of insolvency. The GAO's information was based on a survey sent to insurance regulators in all 50 states and the District of Columbia between April 1987 and January 1989. Of the 51 insurance regulators surveyed, 48 responded. Moreover, during our review of a sample of five foreign insolvent insurers, we found that there was a decided lack of effective communication between state regulators. We discuss three of these insolvent insurers in the following pages.

Midland Insurance Company

Midland Insurance Company (Midland) was a New York domiciled insurer licensed to transact insurance business in all 50 states. Midland was placed into conservation in California in April 1986. New York's Insurance Department failed to effectively communicate with other state regulators about Midland's financial condition. Specifically, the New York department had received requests from other state regulators for information on Midland and its financial problems. However, the New York State comptroller, who reviewed the New York department's files on Midland at our request, concluded that the New York department failed to respond to these requests except to inform one state that Midland was being examined. Also, New York's Insurance Department failed to inform states in which Midland transacted business about other states' various regulatory actions against Midland.

Also, communication was minimal between California's Department of Insurance and New York's Insurance Department. Other than some file memoranda received from the New York

department in 1977 regarding its 1975 examination of Midland and a notification that New York was ordering Midland's liquidation in 1986, we found no evidence that any written communication occurred. Furthermore, California did not receive the results of the 1975 examination until July 1980. The examination was originally to cover the period ending December 31, 1975, but was extended to December 31, 1976. Moreover, the New York department completed another association examination of Midland in January 1983 covering the three years ended December 1980. A California examiner participated in this association examination, and he finished his fieldwork in March 1982. Although the California examiner participated, the California department did not receive a copy of the report until May 1985, more than two years after the report's completion and three years after California's participation. Although the examination concluded that Midland was still solvent at the time, it did note that Midland had significant deficiencies in its loss and loss adjustment reserves. Underreserving was a major cause of Midland's eventual insolvency in 1985.

During the two years between the completion of the examination and the receipt of the report, the California department was aware of deficiencies in Midland's reserves as was evidenced by the department's analyses of Midland's financial statements, Midland's appearance on the department's internal watchlist of insurers that may be experiencing financial difficulties, and indicators from the NAIC's Insurance Regulatory Information System (IRIS) reports. Yet, the California department continued to wait for New York, the domiciliary state, to take the initial regulatory action against Midland. In December 1985, the New York department concluded, through its examination covering the four years ended December 31, 1984, that Midland was insolvent by approximately $24 million. California did not participate in that examination and the New York department never sent the results. In early April 1986, the New York department notified California that it had placed Midland into liquidation on April 3, 1986. The California department placed Midland into conservatorship in the middle of April 1986.

If the California department had received the report of the 1980 association examination sooner, then it would have been aware much earlier of the true magnitude of Midland's underreserving problems. Instead of requesting the report and additional information from the New York department, the California department waited more than two years, despite having concerns about Midland's financial condition. During those two years of waiting, the California department failed to take any active role in regulating Midland. If the two state regulators had communicated consistently, the California department may have been able to take more timely and effective regulatory action, and, thus, it may have been able to mitigate the harm Midland's insolvency caused to California policyholders.

Ideal Mutual Insurance Company

Ideal Mutual Insurance Company (Ideal) was a New York domiciled insurer licensed to transact insurance business in all 50 states. New York's Insurance Department placed Ideal in rehabilitation on December 27, 1984. Ideal was ordered to cease and desist transacting all insurance business except contractually mandated renewals in California on December 28, 1984. However, the New York department failed to effectively communicate with other state regulators about Ideal's financial condition. In fact, the New York State comptroller, who reviewed the New York department's files of Ideal at our request, found that the New York department had received at least 15 inquiries from other states about Ideal's financial condition. However, in addressing 9 of the 15 inquiries, the New York department either offered vague or unresponsive answers or did not respond at all. Consequently, these types of answers failed to effectively communicate the full extent of Ideal's financial problems. Moreover, during the same time the 9 inquiries were made concerning Ideal's financial condition, the New York department's examiners were engaged in an examination of Ideal's records and, therefore, should have been able to provide the specific information requested.

In fact, communication between the California and New York regulators was ineffective. In February 1984, the New York department completed an association examination of Ideal in which California participated. The examination, which covered the three years ended December 1980, began in June 1981 and took more than two and a half years to complete. This examination was extremely important in that it revealed that Ideal's reinsurance arrangements with nonauthorized insurers had grown dramatically, a situation that contributed to Ideal's eventual insolvency. In fact, these arrangements had more than doubled since 1977, representing 58 percent of the premiums written by Ideal. Further, the examination revealed that Ideal was insolvent by $28.5 million, mainly because of Ideal's involvement in unauthorized reinsurance. The amount of Ideal's insolvency was later revised by New York to $6.5 million, based on subsequent events.

The California department did not receive a final copy of the examination report on Ideal until March 1984. The California department contacted the New York department only twice, in August and November 1983, to inquire about the status of the examination. The New York department replied that the results were still preliminary but that Ideal was considered statutorily insolvent. Apparently, the New York regulators had revised the report substantially without California's participation. The New York department completed a subsequent field examination of Ideal in December 1984 covering the three years ended December 31, 1983, and concluded that the magnitude of Ideal's insolvency had grown to more than $155 million.

In addition, although the California department was supposed to analyze the company's financial statements regularly, the only evidence that it ever did so was contained in a letter the department wrote to Ideal on November 30, 1984, discussing the results of its review of the insurer's September 1984 quarterly statement. Rather than regularly reviewing Ideal's financial condition, it appeared, based on our review, that the California department relied principally on the reports of examination conducted by the New York department as its means of determining whether Ideal's

reinsurance arrangements were valid or not. The California department issued a cease-and-desist order against Ideal in December 1984.

Integrity Insurance Company

Integrity Insurance Company (Integrity) was a New Jersey domiciled insurer licensed to transact business in all 50 states. The New Jersey Department of Insurance placed Integrity into rehabilitation in December 1986 and California conserved the company in January 1987. We found that there was a lack of effective communication among state regulators concerning Integrity's operating and financial condition.

Integrity conducted a significant portion of its business in California and Florida. In October 1981, the chief of the California department's financial analysis division noted in a summary that Integrity's business had grown rapidly from 1976 to 1980 and that the number of its managing general agents had grown from one to 23. Based on the chief's concerns, a former commissioner of the California department requested information about Integrity's managing general agents from the Florida Department of Insurance where some of the managing general agents were operating. In addition, the chief of the California department's financial analysis division decided that the division should request similar information from the New Jersey Department of Insurance. However, we could not find any evidence that the California department sent a written request to the New Jersey Department of Insurance or that it received any response from the Florida Department of Insurance.

Between 1981 and 1986, the financial condition of Integrity showed further cause for concern as evidenced by information received from the NAIC and the California department's own analyses of Integrity's financial statements. In September 1986, the financial analysis division recommended that the California department pursue a formal cease-and-desist order against

Integrity. However, in October 1986, the financial analysis division reversed its position because Integrity voluntarily agreed to cease writing all insurance business in California and a proposed purchase of the company was possible at that time. In November 1986, the New Jersey Department of Insurance found Integrity to be financially impaired and requested all state regulators to halt any action to revoke Integrity's license until all attempts had been explored to infuse capital into the company to rehabilitate it. The California department complied with New Jersey's request. The New Jersey Department of Insurance ultimately placed Integrity into rehabilitation in December 1986.

The Department Does Not Always Pursue Information From National Agencies

As part of its regulatory responsibilities, the department screens entrants applying for a new or amended certificate of authority to transact insurance business in California. This screening includes a background investigation of all individuals who serve as officers, directors, major stockholders, and key management personnel of an insurer and the insurer's ultimate parent company.

The company investigations unit (CIU) of the department's financial analysis division is responsible for conducting the screenings. To accomplish these screenings, the CIU contacts various national agencies such as the NAIC or the Securities and Exchange Commission (SEC) and requests any adverse information on the individuals.

However, during our review we noted a lack of coordination between the department and national agencies because the department's system for contacting these agencies has several flaws, including lack of timeliness, relevance, and completeness.

First, the department only contacts the SEC and the NAIC when an insurer is applying for a new or amended certificate of authority. Yet, most violations can occur after the department has

already issued the certificate of authority. The department should periodically contact these agencies, such as during a field examination, when it receives adverse information on an insurer or an individual or when an insurer is suffering from management or control problems.

Second, the department does not coordinate with the SEC to use a unique identifying method when requesting adverse information during the department's screening process. A unique identifier could be as simple as using the individual's social security number. (Although the department does include individuals' social security numbers when requesting information from the SEC, the SEC does not use the social security number or any other unique identifier to sort information.) For example, one of the individuals in our sample was a Michael A. Smith. This is a fairly common name. When the SEC replied that there was adverse information on a Michael A. Smith, we had no way to verify that this information pertained to the correct Michael A. Smith. According to the chief of the financial analysis division, the CIU resolves this problem by contacting the individual and asking the individual to verify whether or not the information obtained applies to him or her. The CIU also ends up attempting to gather other information to verify that the applicant is, in fact, the same person.

Third, although the CIU is supposed to contact the SEC and the NAIC to screen every officer and director of an insurer when the insurer applies for a new or amended certificate of authority, the evidence in the department's files does not show that the CIU did this. It appears that either the CIU did not contact the SEC and the NAIC, or the CIU did not adequately document its screening efforts. Regardless, better and more consistent documentation and verification of these facts is necessary for this process to be useful in the future.

To independently confirm whether any adverse information was available for the directors and officers in our sample of 14 insolvent insurers, we submitted a list with the names of the directors and officers to the SEC and the NAIC and requested them

to conduct a search of their data files. As we show in the following pages, both the SEC and NAIC responded with adverse information on a number of individuals.

Securities and Exchange Commission

The SEC's data base had adverse information on six individuals. These six individuals had similar names to seven directors or officers who were associated with five of the insolvent insurers in our sample. Of the six individuals, five had violations that occurred after the respective insurers had already been granted a new or amended certificate of authority in California. Thus, even though the CIU may have screened these six individuals and requested information regarding them from the SEC, the SEC would not have reported any adverse information on five of them at the time of the request.

The sixth individual was in a unique situation in that he served as an officer for two affiliated companies, Pacific Standard Life Insurance Company (Pacific Standard) and Pacific Standard Life Insurance Company of California (Pacific Standard of California). Specifically, the department had granted Pacific Standard a certificate of authority in 1960, and the sixth individual's violation occurred in 1970. Therefore, the SEC would not have reported any adverse information in 1960. The second company the individual was involved with, Pacific Standard of California, was a subsidiary of Pacific Standard and was created for the purpose of redomesticating Pacific Standard in California. Based on our review of the files for this insurer, the department was in favor of the redomestication of Pacific Standard, and therefore, it did not conduct a full screening of the individuals connected with Pacific Standard of California when the company applied for a certificate of authority in 1987. There was no evidence in the department's files to suggest that the CIU was involved with screening this application. If the CIU had contacted the SEC in 1987, then it would have received adverse information on this one individual.

National Association of Insurance Commissioners

The NAIC has two databases containing information on individuals, the Regulatory Information Retrieval System (RIRS) and the Special Activities Database (SAD). The RIRS gives state regulators on-line access to the names of more than 49,000 insurers, agencies, and agents that have been subject to some type of formal regulatory or disciplinary action as of April 1991. Examples of formal regulatory or disciplinary actions include license revocations, fines, and suspensions. Not every state currently participates actively and routinely in the RIRS. Meanwhile, the SAD is a clearinghouse for more informal information on insurers and individuals who may be involved in questionable or fraudulent activities. The SAD began operations in June 1990.

The NAIC's RIRS database had adverse information on 11 individuals with similar names to 11 directors and officers associated with eight insolvent insurers in our sample. Of the 11 individuals, 9 had violations or adverse information that occurred after the respective insurers had already been granted a new or amended certificate of authority in California. Therefore, even if the CIU had screened these 9 individuals and requested information concerning them from the NAIC at the time when their respective insurers applied to the department, the NAIC would not have reported any adverse information on them.

Of the remaining two individuals, one had his license revoked and the other had his license suspended before the department had granted amended certificates of authority to the insurers they were affiliated with. Therefore, had the CIU contacted the NAIC at the appropriate time, the NAIC would have reported adverse information on these individuals. However, there was no evidence in the department's files indicating the department ever contacted the NAIC about these two individuals or was aware of the adverse information concerning them.

The NAIC's SAD had adverse information on 17 individuals whose names were similar to those of the directors and officers of the insolvent insurers in our sample. However, because of the

NAIC's policy of only providing information from the SAD to state insurance departments and law enforcement officials, we were unable to review the information on these 17 individuals.

Conclusion

In general, we found that state regulators were reluctant to share information with one another about financially troubled insurers. This lack of effective communication is consistent with the results of the GAO's report containing a survey of 51 state regulators. The report showed that only 15 regulators would provide full disclosure of information upon request to states in which a financially troubled company was licensed. Moreover, we found that the California department did not diligently pursue information that could have shed light on the financial problems of the foreign insurers in our sample that became insolvent. The California department was aware that these insurers had potentially serious financial problems yet waited for lengthy periods before taking any action to obtain relevant information from the domiciliary state of these insurers.

Even when the California department did inquire about the status of a financially troubled insurer, it failed to adequately follow up on the information provided. In instances where the domiciliary states failed to take effective regulatory action, the California department still opted to wait and let the domiciliary state take the initial action rather than act independently to protect California policyholders. Because much of the insurance business written in California is accomplished through foreign insurers, the California department must take more aggressive regulatory action to protect California policyholders rather than wait unnecessarily for the domiciliary state to take the needed action.

Finally, the system that the California department uses to screen out undesirable directors, officers, major stockholders, and key management personnel of insurers wishing to transact insurance business in this state is not as effective as it could be.

Recommendations

To improve the effectiveness of communications between the department and other state regulators, the department should institute a more effective and assertive communication system with other state regulators. Moreover, the California department should give the domiciliary state an opportunity to apply regulatory pressure on a financially troubled insurer to correct its financial problems. However, if the domiciliary state does not take the actions necessary to ensure the insurer effectively corrects the problems identified, then the California department needs to take the initiative in ensuring that the insurer takes the necessary corrective actions.

To improve coordination between the department and national agencies, the department should revise its method of screening officers, directors, major shareholders, and key management personnel of insurers applying for new and amended certificates of authority. The screening method should include more frequent requests for information from national agencies, a unique identifying system for obtaining information relating to specific individuals, and more complete documentation of the information obtained.

Chapter 3 The Costs of California's Insurance Guarantee Association for Property and Casualty Insolvencies Are Increasing

Chapter Summary

California established the California Insurance Guarantee Association (CIGA) and California Life Insurance Guarantee Association (CLIGA) to protect covered policyholders within specified limits from losses due to insolvencies of property and casualty and life insurers. Both associations are managed by boards whose members are appointed or approved by the insurance commissioner. Because the legislation establishing the CLIGA took effect as recently as January 1991, insufficient data existed for us to analyze the costs of life insurers' insolvencies. However, we did determine that, as the frequency of property and casualty insolvencies has generally increased over time, so has the financial cost of paying for these insolvencies. In 1986, the CIGA paid more than $67.1 million for losses and expenses of insolvent insurers. By 1989, that amount had increased to approximately $173 million, an increase in the amount the CIGA paid out over three years of approximately 157 percent.

Consequently, to pay for the increasing costs of insolvencies, the CIGA has had to charge its member insurers more in assessments. In 1986, the CIGA collected approximately $122 million in assessments from its member insurers. By 1989, that amount had risen to more than $253 million. This reflected an increase in the assessments the CIGA collected from its member insurers of approximately 108 percent. These member insurers then pass the cost of these assessments on to the insurance buying public in the form of premium surcharges.

California Insurance Guarantee Association

California created the California Insurance Guarantee Association (CIGA) in 1969 for the purpose of providing insolvency insurance to property and casualty insurers transacting insurance business in California. Insolvency insurance is insurance against loss arising from the failure of an insolvent insurer to fully cover its insurance policy obligations. All property and casualty insurers in California, except insurers transacting only specific exempted lines of insurance, must be members of the CIGA to retain their authority to transact insurance in California.

When a member insurer becomes insolvent, the CIGA will collect assessments from its other members to cover the incoming claims and the cost of adjusting those claims. Before 1990, the CIGA separated assessment payments according to three categories: workers' compensation, automobile, and other. The automobile category includes physical damage to automobiles and automobile liability lines of insurance while the other category includes the remaining lines of insurance besides workers' compensation and automobile, such as homeowners', fire, burglary, and general liability. In 1990, the automobile category was expanded to include homeowners' claims. According to law, the assessments charged to each member insurer will not exceed one percent of its net direct premiums written in California during the preceding calendar year for each category. After the CIGA has paid all the covered claims of an insolvent insurer and any administrative expenses, it retains any remaining unused assessments collected for a given category and applies these to reduce future premium charges.

Each member insurer is permitted to recover the assessments paid to the CIGA by applying a policy surcharge to its customers. The CIGA determines the rate of the surcharge and the collection period for each category. If a member insurer collects surcharges exceeding the amount of assessments it paid, then the member insurer gives the excess surcharge to the CIGA. The CIGA will then apply the excess amount to the member's account, thus reducing future assessments.

The CIGA covers claims associated with most property and casualty lines of insurance transacted in California, such as fire, inland marine, liability, workers' compensation, burglary, and automobile. However, except for workers' compensation claims, the CIGA will not cover individual claims in excess of $500,000. The California Insurance Code does not specify any limit on workers' compensation claims. In addition, the CIGA will not cover certain lines of insurance such as life and health, investment guaranty, fidelity or surety, credit, and title. The CIGA also will not cover claims arising out of reinsurance contracts, claims incurred after insurance policies have expired, been replaced or cancelled at the policyholder's request, or any obligations to a state or federal government, nor will the CIGA cover claims for punitive or exemplary damages.

In some cases, when a California resident makes a claim to another state's association, the claimant may be covered by both the CIGA and the other state's association. These cases arise when the liable party is from another state except for certain claims involving property damage. In these dual-coverage cases, California residents must first seek recovery from the other state's guarantee association. If the other state's guarantee association does not fully cover the amount of the claim, then the CIGA will cover some or all of the difference depending upon the applicable limits. For situations involving damage to property with a permanent location, the claimant must first seek recovery from the guarantee association of the state in which the property is located. If the claim is for workers' compensation, then the claimant must seek recovery from the guarantee association of the state in which he or she resides.

Summary of CIGA's Operations

Based on financial statements the CIGA provided, we were able to compute the CIGA's paid losses and expenses and collected assessments for each calendar year from 1986 through 1989. We computed these amounts for each of the three general categories of insurance the CIGA covers. Initially, we had intended to compute these amounts for calendar years 1985 through 1989. However,

because of the CIGA's accounting methods and the unavailability of records, we were unable to calculate the CIGA's paid losses and expenses and collected assessments for calendar year 1985. In addition to computing paid losses and expenses and collected assessments, we computed the maximum assessments available to the CIGA for calendar years 1986 through 1989 for each of the three general categories of insurance claims the CIGA covers.

Table 3 shows the amounts of losses and expenses the CIGA paid during calendar years 1986 through 1989 for each category of coverage. Expenses included both the costs of adjusting claims and the costs of administration.

Table 3 Losses and Expenses the CIGA Paid by Category and in Total 1986 Through 1989

	Auto	Other	Workers' Compensation	Total
1986	$26,217,585	$ 35,031,334	$ 5,896,939	$ 67,145,858
1987	51,628,243	84,594,042	49,964,980	186,187,265
1988	34,744,289	105,864,406	63,465,223	204,073,918
1989	66,641,485	56,480,332	49,792,693	172,914,509

Source: The CIGA's unaudited financial statements.

As illustrated in Table 3, losses and expenses generally increased for all three categories during the period covered, with 1988 being the most costly year for the CIGA. The total amount of losses and expenses for all categories increased by approximately 157 percent from more than $67.1 million in 1986 to approximately $173 million in 1989. However, the total amount the CIGA paid for losses and expenses decreased from $204 million paid in 1988 to approximately $173 million paid in 1989.

Table 4 shows the amounts of assessments the CIGA collected from member insurers during calendar years 1986 through 1989 for each category the CIGA covered.

Table 4 Assessments the CIGA Collected by Category and in Total 1986 Through 1989

	Auto	Other	Workers' Compensation	Total
1986	$46,831,967	$ 68,278,281	$ 6,539,653	$121,649,901
1987	46,931,033	56,435,817	23,987,079	127,353,929
1988	43,198,563	78,858,285	38,960,306	161,017,154
1989	65,388,932	93,473,618	94,381,682	253,244,232

Source: The CIGA's unaudited financial statements.

As illustrated in Table 4, the CIGA generally increased the assessments it collected for all three categories during the four years. However, for the "other" category, assessments did decline in 1987, and they also slightly declined for the auto category in 1988. In addition, while assessments collected for the auto category were fairly stable, the assessments collected for the workers' compensation category experienced large increases such as the increase between 1988 and 1989 when assessments collected increased from approximately $39 million to more than $94 million. This change represented a one-year increase of 142 percent in collected assessments. As shown in Table 4, the total amount of assessments the CIGA collected increased significantly during the four years. In fact, assessments the CIGA collected have more than doubled from approximately $122 million in 1986 to more than $253 million in 1989.

Table 5 shows the maximum amount of assessments available to the CIGA during calendar years 1986 through 1989 for each category covered by the CIGA. The maximum amount of assessments available to the CIGA during any given year equals one percent of the net direct premiums member insurers write in California for each designated category during the preceding calendar year.

Table 5 Maximum Assessments Available to the CIGA by Category and in Total 1986 Through 1989

	Auto	Other	Workers' Compensation	Total
1986	$ 86,022,730	$ 79,677,450	$ 36,596,400	$202,296,580
1987	104,275,970	100,488,380	46,273,230	251,037,580
1988	116,176,810	104,505,690	56,011,760	276,694,260
1989	127,128,670	101,474,760	65,713,310	294,316,740

Source: The CIGA's unaudited financial statements.

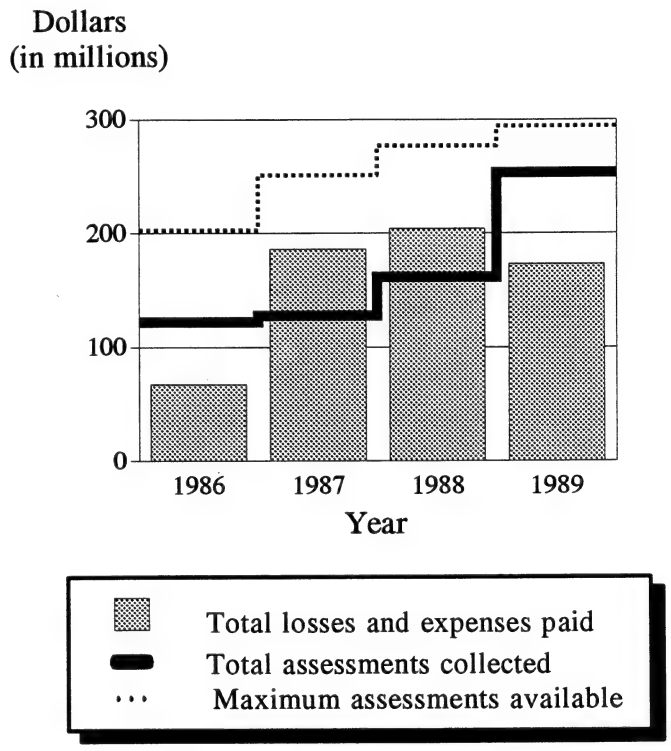
As shown in Table 5, the maximum assessments available to the CIGA for each category and in total has also generally increased during the period, reflecting increases in the amounts of net premiums member insurers write for each category. For example, the total maximum assessments available has increased from approximately $202 million in 1986 to approximately $294 million in 1989.

Figure 5 presents a comparison of the total amounts of losses and expenses paid, assessments collected, and maximum assessments available to the CIGA for calendar years 1986 through 1989.

Figure 5

Losses and Expenses Paid, Assessments Collected, and Maximum Assessments Available to the CIGA

1986 Through 1989



Source: The CIGA's unaudited financial statements.

As illustrated in Figure 5, in 1987 and 1988, the CIGA paid out more in losses and expenses than it collected in assessments. However, for all four years, the CIGA had not exceeded its maximum capacity to charge and collect assessments from its

member insurers. In other words, the CIGA could have charged its member insurers more in assessments during those four years than it did.

According to a study A.M. Best conducted of property and casualty insolvencies, the assessments needed to cover the cost of property and casualty insolvencies nationally have also been increasing. For example, nationally, between approximately 1985 and 1989, assessments for guarantee associations have increased from 0.25 percent to 0.46 percent of the industry's net written premiums. However, the amount of net assessments paid have not been able to fully cover the as yet unassessed projected future costs of past insolvencies, and so additional assessments are necessary in future years to cover the total projected costs of past insolvencies. In other words, the backlog of these as yet unassessed but projected costs is growing. Consequently, according to A.M. Best, annual guarantee fund costs for past insolvencies will be with the industry for some time to come.

According to our calculations, assessments the CIGA collected from 1986 through 1989 have ranged from 0.51 percent to 0.86 percent of California's direct net written premiums. Table 6 shows the assessments the CIGA collected between 1986 and 1989 as a percentage of the direct net premiums written in California from 1985 through 1988.

Table 6 Assessments the CIGA Collected From 1986 Through 1989 as a Percent of Direct Net Written Premiums in California 1985 Through 1988

Year	Assessments the CIGA Collected	Year	Direct Net Written Premiums in California	Percent
1986	$121,649,901	1985	$20,229,658,000	.60%
1987	127,353,929	1986	25,103,758,000	.51
1988	161,017,154	1987	27,669,426,000	.58
1989	253,244,232	1988	29,431,674,000	.86

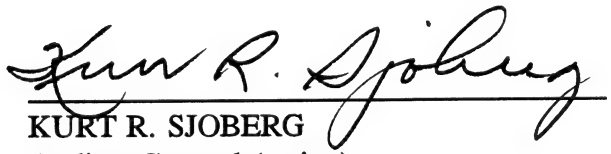
Source: The CIGA's unaudited financial statements.

Conclusion

As the frequency of property and casualty insolvencies has increased over time, so has the financial cost of paying for those insolvencies. In 1985, the amount of losses and expenses the CIGA paid for insolvent insurers was more than $67.1 million. By 1989, the amount of losses and expenses the CIGA paid on behalf of insolvent insurers had grown to approximately $173 million. Consequently, the CIGA has had to charge its member insurers more in assessments. In 1986, the CIGA collected approximately $122 million in assessments. By 1989, the amount of assessments had risen to more than $253 million. Member insurers pass these assessments on to the insurance buying public through policy surcharges. Although insolvencies can never be entirely eliminated from the insurance industry, when insolvencies do occur, the costs are ultimately borne by the insurance buying public.

We conducted this review under the authority vested in the auditor general by Section 10500 et seq. of the California Government Code and according to generally accepted governmental auditing standards. We limited our review to those areas specified in the audit scope section of this report.

Respectfully submitted,



KURT R. SJOBERG
Auditor General (acting)

Date: June 23, 1992

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Appendix A Detailed Description of Problems That Led to the Insolvency of a Sample of Insurance Companies

Cadillac Insurance Company

California Pacific Life Insurance Company

California Standard Indemnity

Coastal Insurance Company

Colony Charter Life Insurance Company

Executive Life Insurance Company

First California Property and Casualty Insurance Company

Homeland Insurance Company

Ideal Mutual Insurance Company

Integrity Insurance Company

Midland Insurance Company

Mission Insurance Company

Pacific Standard Life Insurance Company

Transit Casualty Insurance Company

Cadillac Insurance Company

Cadillac Insurance Company

State of Domicile: Michigan
Net premium written in 1988: $40.7 million
Status: liquidated February 1990

Hazardous Conditions Exhibited		Year First Noted
Questionable investments	☐	
Improper reinsurance	☐	
Improper affiliate transactions	☐	
Reserve deficiencies	☐	
Poor underwriting	☐	
Poor use of managing general agents	☐	
Agents' high balances	☑	1985

Cadillac Insurance Company (Cadillac) was domiciled in Michigan and authorized to transact insurance business in California. Cadillac received authority from California's Department of Insurance (department) to transact certain lines of casualty business in California beginning in September 1984. One factor that contributed to the eventual failure of Cadillac was uncollectible agents' balances. While the department was able to detect this hazardous condition well before Cadillac's failure, it did not ensure that the company took prompt and effective action to correct it. Following is a detailed presentation of the factor leading to Cadillac's failure.

Agents' High Balance

As early as 1985, the California department found that, in a review of Cadillac's 1985 quarterly statements, Cadillac had written more direct premiums in the first six months of 1985 than it had in the

entire previous year, indicating that it was rapidly expanding its business. Direct premiums represent the money an insurer collects for the insurance policies it issues. In addition, by September 1985, Cadillac's reported agents' balance was higher than the National Association of Insurance Commissioners (NAIC) considers normal for the industry in relation to its surplus. According to the NAIC's interpretation, the ratio of agents' balance to surplus measures the degree to which an insurer's solvency depends on an asset that frequently cannot be converted to cash. The ratio is reasonably effective in distinguishing a troubled company from a sound one. An agents' balance is an asset account insurers use to recognize the amounts its agents owe to the company for the premiums they collect on the insurer's behalf. Because the company had written so many direct premiums and because of the agents' high balance, the department examiner noted that Cadillac had failed his summary analysis for 1985 and recommended the company be placed on the department's watchlist.

In July 1986, after reviewing Cadillac's quarterly financial statements, the department examiner found that Cadillac continued to rapidly expand the volume of premiums it was writing and still exhibited a high balance for agents in relation to its surplus. The department examiner was also skeptical of the company's ability to properly prepare its financial statements and recommended that Cadillac be required to limit the amount of its net written premiums to no more than was written in 1985. The chief of the department's financial analysis division discussed some of the department's concerns with Cadillac's president. The chief advised the president that the department would review Cadillac's June 1986 quarterly statement and would probably restrict the amount of premiums Cadillac could write in California if the department continued to have concerns regarding Cadillac. After a review of Cadillac's June 1986 quarterly statement, the examiner concluded that the earlier discussions had failed to curb the amount of premiums Cadillac was writing. The examiner noted that the ratios of net written premiums and agents' balance to surplus were considered to be hazardous to Cadillac's financial condition and recommended that the company be upgraded from the "watch" category to the "special reporting" category. However, the examiner's supervisor

instructed him to change the regulatory status of Cadillac to "monthly reporting." An insurer's surplus is the amount by which the assets of the insurer exceed its liabilities less capital. According to the department's watchlist categories, a "watch company" shows signs of having potentially serious problems. A "special reporting" company is required to provide periodic reports or correspondence to the department. A "monthly reporting" company must file financial statements with the department each month.

In September 1986, the department sent a letter to Cadillac's president requesting that the company curtail its premium writings in California and requiring that the company file monthly financial statements with the department. The letter further warned that, if Cadillac failed to curtail its writings in California, the department would issue a cease-and-desist order against Cadillac. Shortly thereafter, according to a letter written to the department from Cadillac's president, Cadillac's parent company, Arlans Agency, Inc., contributed $2 million in cash to Cadillac's surplus so as to improve its ratios, and the department subsequently dropped its request that Cadillac curtail its writings in California. However, the department did continue to require monthly statements from Cadillac.

During 1987 and 1988, both the department's review and the NAIC's reports of key financial ratios found that Cadillac continued to have a high balance for agents in relationship to its surplus. In June 1988, a supervising insurance examiner in the department's financial analysis division sent a letter to Cadillac's president requesting him to voluntarily cease writing any new business in California. Among the department's reasons for this action, the examiner cited Cadillac's balance for agents in relation to Cadillac's surplus, a deteriorating liquidity position, loans to officers that the California Insurance Code prohibits, and improper affiliate transactions. In September 1988, Cadillac's president agreed to restrict the volume of premiums in California to no more than was written in 1987 and to diligently work toward reducing the agents' balance. At that time, the president was also aware that the department was considering a special examination of Cadillac to begin around March 1989.

In March 1989, the NAIC's report of key financial ratios computed from Cadillac's 1988 annual statement indicated that the company still had a high balance for agents in relationship to its surplus. Furthermore, at the end of March, the department's chief examiner of the field examination division informed the former commissioner that a financial examination in progress at Cadillac revealed the company was either statutorily impaired or insolvent. Statutory impairment occurs when the assets of an insurer are less than the sum of the insurer's required minimum capital and surplus and all its liabilities. In April 1989, the department issued a cease-and-desist order against Cadillac requiring the insurer to immediately discontinue writing any new or renewal business in California except such renewal business as may be mandated by contract. Cadillac was conserved in Michigan in July 1989. In January 1990, the former California insurance commissioner petitioned the court to become the conservator of Cadillac in California.

According to the Michigan Insurance Bureau's complaint for conservatorship, as of March 31, 1989, Cadillac was insolvent by approximately $18 million, and the unpaid agents' balance owed by Cadillac's parent company, which was also Cadillac's agent, totaled approximately $17 million.

As early as May 1985, the department found that Cadillac's reported agents' balance was higher than the NAIC considers normal for the industry. Despite a continued pattern of excessively high balances for agents during the next four years, noted by both the NAIC and the department's own analyses, the department did not take any effective action to require Cadillac to correct the problem.

California Pacific Life Insurance Company

California Pacific Life Insurance Company

State of Domicile: California
Net premium written in 1988: $11.9 million
Status: liquidated August 1989

Hazardous Conditions Exhibited		Year First Noted
Questionable investments	☑	1984
Improper reinsurance	☐	
Improper affiliate transactions	☑	1983
Reserve deficiencies	☑	1983
Poor underwriting	☐	
Poor use of managing general agents	☐	
Agents' high balances	☐	

California Pacific Life Insurance Company (CPL) was owned by California Pacific Insurance Services, Inc. (CPIS). CPL began transacting insurance in 1981. CPIS provided management services to CPL under a 1981 agreement. The California Department of Insurance (department) placed CPL in conservation from June 2, 1983, until June 29, 1984, because of significant losses from its group accident and health business in 1982 and 1983. However, as determined in a special, limited examination the department conducted, the company made a financial recovery after its conservatorship and was profitable until 1987 when it suffered a loss from operations.

The factors that contributed to the failure of CPL were reserve deficiencies, questionable investments, and improper affiliate transactions. While the department was able to detect these hazardous conditions well before CPL's failure, it did not ensure

that the company took prompt and effective action to correct them. Following is a detailed presentation of those factors that contributed to CPL's failure.

Reserve Deficiencies

The first time the department noted concerns regarding CPL's reserves and reserving practices was in April 1983 during a special examination of CPL. The purpose of the examination was to determine the financial condition of CPL as of December 31, 1982, and give an opinion on the financial effect of material transactions occurring after that date. According to the examination report, CPL wrote approximately $20 million in premiums in 1982, primarily in accident and health business, roughly 28 times the amount of its reported capital and surplus for that year.

In explaining the rapid increase in the amount of business CPL wrote, the report stated the insurer had begun writing, in January 1982, a portion of the group life and disability business for a multiple employers' trust managed and administered by CPIS, CPL's parent company. However, the primary insurer for the trust until April 30, 1982, had been another insurance company located in Kansas. In April 1982, the Kansas insurer terminated its agreement with CPIS, and CPL received a portion of that business as well. As a result, CPL's net premium volume increased from $620,000 in 1981 to approximately $20 million in 1982.

Further, the examination report stated that CPL had reported a net loss of approximately $1.4 million on its accident and health business for 1982 that, had it not been for an excess of loss reinsurance agreement, would have rendered the insurer insolvent. An excess of loss reinsurance agreement is an agreement with another insurance company whereby reported losses beyond an agreed percentage of premium or a specified dollar amount are reimbursed by the reinsurer. However, effective January 1, 1983, CPL's reinsurer cancelled the excess of loss reinsurance agreement along with another reinsurance agreement leaving CPL without any reinsurance protection. In March 1983, CPL entered into a new

reinsurance agreement with a nonadmitted insurer located in Alabama to reinsure all of its group life and disability business in force, approximately $20 million, with the agreement taking effect on January 1, 1983. According to the department's examiner, the reinsurance agreement with the nonadmitted insurer had the effect of reinsuring substantially all of CPL's business, and, therefore, required the approval of the insurance commissioner. The insurer did not receive such approval. Moreover, all new group life and disability business CPL wrote after January 1, 1983, associated with the multiple employers' trust that CPIS managed would be retained by CPL. Furthermore, according to the information the examiner obtained from CPL's parent company, all claims reported in 1983 on the business that CPL reinsured would be handled by the nonadmitted insurer. CPL would pay all claims incurred before 1983. However, the examiner also stated that, to the best of his knowledge, neither CPL nor its parent company withheld funds or obtained other guarantees from the nonadmitted insurer as a means of ensuring the payment of claims on the reinsured business.

In discussing CPL's reserves, the examiner stated that he accepted as adequate the accident and health reserves and the life reserves CPL reported as of December 31, 1982. (Reserves are funds designated by insurers to be used for the payment of current and future policyholders' claimed losses.) However, he also stated this conclusion was based on data CPL's consulting actuaries provided, and the examiners did not have time to verify the actuarial data through a detailed review of claim files. Furthermore, in commenting on CPL's reserving practices for the first two months of 1983, the examiner stated that the insurer's consulting actuaries did not prepare the life reserves and claim reserves, but instead, CPL's accounting staff estimated them. The examiner stated that the claim reserves reflected CPL's estimate of the amount needed to settle claims occurring before 1983, plus reserves on the new business written in 1983. Moreover, the examiner stated that CPL was unable to provide the reserve figures relating to the business CPL reinsured with the nonadmitted insurer. Without such reserve estimates, the examiner stated it was not possible to measure the impact on CPL's financial condition

should the reinsurer fail to perform. However, the examiner did conclude that CPL's capital and surplus was totally inadequate to support the volume of business written. Finally, the examiners found that CPL's capital and surplus, after reflecting the examination adjustments, did not meet the minimum required by the California Insurance Code to transact life and disability insurance in California.

Shortly after this examination was completed, in June 1983, the department placed CPL in conservatorship because the examiners determined it was statutorily insolvent by about $100,000. The department lifted the conservatorship order in June 1984 because CPL had demonstrated an improvement in its financial condition and practices.

In April 1985, the NAIC recommended CPL be accorded targeted regulatory attention because of CPL's history of persistent loss and its dependence on surplus contributions. According to the NAIC's analysis of CPL's 1984 annual statement, an infusion of additional capital or surplus, or both, during the year and a gain from operations enabled CPL to remain statutorily solvent. In other words, without the contribution made to its capital or surplus, or both, and the operating gain, CPL would not have had sufficient resources to legally transact insurance business in California.

In March 1986, the NAIC again recommended CPL be accorded targeted regulatory attention based on its analysis of key financial ratios computed from CPL's 1985 annual statement. The NAIC commented in its report that CPL was not setting up group life or accident and health reserves at a time when the company had increased its writing of accident and health business. Between June 1984 and April 1986, the department required CPL to file monthly financial statements. However, after April 1986 and contrary to one examiner's opinion, the department began allowing CPL to file quarterly statements.

In May 1986, the department's financial analysis division requested that the field examination division review CPL's loss experience and profitability for its group accident and health

business during its regular triennial examination as of December 31, 1985. In the examination report, completed in June 1986, the examiners noted that CPL's premiums had fluctuated dramatically during the past five years. CPL wrote approximately $7.3 million in premiums in 1985 compared with $2.7 million in premiums the year before. According to the NAIC's interpretation, rapid increases in the level of premiums written may indicate the possibility that management has perceived an immediate need for additional funds in the company. The examiners found the estimates for loss reserves provided by CPL's actuarial consultants acceptable, but did not comment on the profitability of CPL's group accident and health business.

In April 1988, after its analysis of CPL's 1987 annual statement, the NAIC recommended CPL receive immediate regulatory attention. The NAIC's recommendation was based on a $1.8 million decrease in CPL's capital and surplus and a $1.5 million net loss from operations the insurer reported for the year. Further, during that same month, staff from the department's financial analysis division recommended that an immediate special examination be scheduled for CPL because of its decline in surplus and an increase in its ratio of losses and negative cash flow from operations. The recommended purpose of the examination would be to see if conservation of CPL was necessary or whether the department should order the insurer to cease writing any new business.

As a result of the financial analysis division's recommendation, an examiner from the department conducted a limited special examination of CPL, completed in April 1988, covering the period ended March 31, 1988. The purpose of the examination was to assess CPL's financial condition, including its current operating and cash flow position; determine the adequacy of CPL's claim reserves for its accident and health business, and review its level of accident and health writings. From his review of the operating results for January and February 1988, the examiner found that the losses CPL had suffered in the final months of 1987 had abated and that the insurer's cash flow was positive. However, he cautioned that the results of his limited examination of CPL could not be

taken as indicative of a trend for 1988. Further, according to the examiner, both he and CPL's consulting actuary believed that although CPL suffered losses in late 1987, unless the health care industry experienced an unusually bad year of losses, the insurer would have a more profitable year in 1988.

The examiner also mentioned that, according to CPL management, the company had tightened its underwriting standards through such measures as better screening of potential applicants for insurance, a newly designed policy with better cost containment features, and the discontinuance of some of CPL's more unprofitable portions of its accident and health business. Although the examiner stated that these measures were evident during his examination, he cautioned that it was still too soon to gauge their success. The examiner also noted that CPL had increased its premium rates for accident and health business by 20 to 30 percent without any appreciable decreases occurring in the rate of renewals for these lines. Finally, the examiner concluded that, while a conservatorship of CPL was not indicated, the department should closely monitor the company's quarterly financial statements to detect any adverse trends during the remainder of 1988. He also recommended that the department schedule a full examination as soon as possible after the close of calendar year 1988. Lastly, the examiner stated that although the company had taken certain measures to decrease its writings of accident and health business, the department should formally request that CPL reduce, but not cease, its writings in those lines to levels below those reached in 1987.

In May 1988, the department required CPL to file monthly financial statements with the department and immediately stop writing any more new business in 1988. CPL agreed to comply with the department's request in June 1988.

In August 1988, one of the department's examiners noted that CPL suffered a net loss of approximately $1.2 million and a 63 percent decline in capital and surplus during the first six months of 1988. The examiner warned that, at its present level of net losses, CPL's reported capital and surplus of $657,000 at

June 30, 1988, would not last until the end of the year. Furthermore, the examiner stated he would be surprised if CPL's reserves were not deficient. Finally, he recommended that the department require CPL to immediately obtain an augmentation to its surplus of at least $2.5 million, and if the company failed to comply, require it to cease writing all business in California.

During September 1988, three states took formal actions against CPL. Mississippi notified the insurer that if the deficiency in its surplus was not corrected to the satisfaction of the state's insurance department within 30 days, CPL's license in that state would be revoked. Nebraska put CPL under state supervision and prohibited it from writing any new or renewal business in that state. Finally, Kansas suspended CPL's certificate of authority to write any new or renewal business in that state. However, California took no such formal legal actions. Instead, one of the department's senior examiners visited CPL's home offices in September 1988. The purpose of the visit was to follow up on the department's limited examination conducted in April 1988 and find out what, if any, plans management had for the company and improvement of its operations.

The examiner stated in a memorandum that, as a result of actions the department requested, the company had ceased writing any new business but was continuing to renew existing business, was submitting monthly financial statements to the department, and was in the process of increasing the premium rates charged on its renewal accident and health business. Further, in explaining the deterioration in financial condition evidenced in CPL's quarterly statements for June 1988, the department's senior examiner stated that it was the result of the company's consulting actuary increasing reserves. Moreover, CPL's management also contended that the company's surplus had increased by $250,000 as of July 1988 and should improve further or stabilize as operations level off to reflect CPL's reduced writing and expenses. Finally, the management of CPL stated to the department's senior examiner that CPL had begun seeking prospective buyers for the insurance company and its holding company. Therefore, CPL's management stated that it would like to obtain a sales transaction before the department

issued an order to conserve the company so that the company could maximize its value to any potential buyers. CPL's management told the examiner that, to avoid conservation, CPL would consider an infusion of capital into CPL if the department required.

In March 1989, the department notified the legal counsel for CPL that it would have no choice but to conserve CPL if the insurer failed to demonstrate to the department that it had obtained a $2.7 million infusion of cash or other acceptable assets into the company by March 27, 1989. During April 1989, one of the department's examiners wrote a memorandum to the chief of the financial analysis division regarding the examiner's analysis of CPL's 1988 annual statement and February 1989 monthly statement. The examiner noted that, as of December 31, 1988, CPL was insolvent with a reported deficit in its surplus of more than $120,000. However, CPL's monthly statement for February indicated that a $3.8 million infusion was made to surplus during the month resulting in a reported capital and surplus of $3.9 million. According to the examiner, the surplus infusion was supposedly funded by bonds and common stocks although CPL did not include any details concerning these assets. Furthermore, the examiner stated that the monthly statement was not signed; however, the company promised a fully executed and notarized version shortly.

Also, during April 1989, a year after it had conducted a special examination of CPL, the field examination division completed another special examination of the insurer as of February 28, 1989. The department examiner found the company had paid virtually none of its accident and health claims since November 1988, nor had CPL paid numerous other claims received before November. Further, the examiner noted that one of CPL's claims administrators had terminated its contract with CPL because CPL would not forward more than $800,000 owed for the settlement of processed but unpaid claims. In addition, CPL's consulting actuaries now doubted the accuracy of the reserves they had established for CPL as of February, having been informed by the examiner of the large volume of reported but unpaid claims CPL owed. The examiner planned to question one of the actuaries to

determine if the actuary had received accurate information from the company to establish credible claim reserves. Finally, the examiner determined that, as of February 28, 1989, CPL had a deficit in capital and surplus of $1.4 million. On May 19, 1989, the former commissioner was appointed by the court as conservator of CPL and began proceedings to liquidate the insurer on August 2, 1989.

The department had detected CPL's potential reserving problems as early as April 1983. Despite a history of losses associated with CPL's accident and health business, a warning from the NAIC concerning CPL's failure to set up reserves when the company had increased writings in those lines of business, and some form of formal regulatory action taken against CPL by three different states in 1988, the department chose to send one of its examiners to visit CPL's home offices. The examiner went to the offices to find out what plans CPL management had to improve operations. Despite this action, the department learned in April 1989 that CPL had not been paying for any claimed losses since November 1988.

Questionable Investments

Beginning in April 1984, the NAIC recommended CPL receive immediate regulatory attention, citing the company's low-investment yield as a reason. In March 1986 and March 1987, the NAIC found that CPL still had the same problem.

The department completed an examination of CPL in June 1986 to determine the company's financial condition as of December 31, 1985. The examiners noted that CPL did not hold meetings of the board of directors and stockholders as was the general practice in the industry. Instead, the insurer's bylaws provided that "letters of unanimous written consent" signed by the directors could substitute for such meetings when major matters arose. Further, the examiners stated that although CPL's minutes contained no approval of security transactions, the company's bylaws provided that the signing of any written instrument by a director or officer was binding. Examiners also identified one

mortgage loan of $100,000 made to a CPL director as violating the law. This loan was repaid in April 1986. Finally, the examiners stated that the records of ownership regarding the insurer's certificates of deposit were unclear.

In September 1987, after reviewing CPL's 1986 annual financial statement, the department questioned CPL about the underlying values of more than $2 million worth of the assets and securities the company held and why they should be considered acceptable assets according to insurance code requirements. Specifically, the department requested CPL obtain independent valuation for some of its investments in stocks, explain and justify the values shown for two loans it made, and indicate when amounts due to it were paid. CPL's secretary responded to the department the same month, clarifying the values and nature of the assets. Once again, in March 1988, the NAIC noted that CPL still showed a low-investment yield.

In April 1988, the department completed a special examination of CPL. The examiner noted the company had speculative investments in securities and recommended CPL's funds be placed in more conservative investments. In response to the examiner's recommendation, CPL contended it was in the process of selling its speculative stocks and purchasing top grade corporate or government obligations. The examiner commented that there was some evidence this process had begun. Although the examiner revisited CPL in September 1988 to follow up on his examination, he did not report whether CPL was, in fact, selling off its speculative securities.

One year later, in April 1989, the department completed another special examination of CPL and found the company had made unsound investments in collateral loans and speculative stock in the past, and CPL's financial statements showed these assets at values exceeding their true market value by more than $570,000. These overvalued assets were reduced during the examination, causing a decline in CPL's surplus by a similar amount. During this special examination, examiners found CPL to be insolvent by approximately $1.5 million.

In 1984 and again in 1986 and 1987, the NAIC, in its analysis of CPL's financial statements, had warned that the insurer was showing an unusually low investment yield. Furthermore, during examinations of CPL completed in 1986 and 1988, the department had criticized the insurer for making an illegal loan, having unclear records of ownership concerning its certificates of deposit, and making speculative investments in securities. However, the department did not ensure CPL took the necessary actions to correct its investment practices until an examination in 1989 found the insurer to be insolvent partly because of overvalued investments.

Improper Affiliate Transactions

As mentioned earlier, California Pacific Insurance Services, Inc., owned and controlled CPL. CPIS's principal activities were the management and administration of CPL and an affiliate. In April 1983, during a special examination of CPL, the department noted CPL had a management agreement with CPIS whereby CPIS would provide management services to CPL in exchange for a variable fee. The department also noted that, during 1982, CPL paid approximately $370,000 to CPIS as compensation for its management and administrative services and that this amount exceeded the amount specified in CPL's management agreement by approximately $40,000. Management agreements among affiliates can be hazardous to an insurer when the insurer pays more to the affiliates than the costs of the services rendered. Such overcharging by affiliates has the effect of funneling cash from the insurer and creating a drain on its surplus.

During the same examination, the department also noted the company could not provide a satisfactory account of the disposition of an approximate $200,000 loan, which the company borrowed in November 1981. The company stated that the purpose of the loan was to improve its home office. However, according to a company memorandum, the loan proceeds were deposited into an operating account belonging to CPIS and were used by the bank to pay off a line of credit for CPIS.

In February 1987, CPL reported to the department four major transactions involving affiliates. The transactions included purchasing approximately $160,000 worth of CPIS stock from a third party, purchasing real estate from CPIS for $700,000 along with the assumption of existing encumbrances, loaning $360,000 to CPIS, and collateralizing other loans totaling approximately $560,000 made to CPIS. We could not find any evidence the department contacted CPL regarding these affiliate transactions.

In March 1988, the department received a letter from a person requesting anonymity. The letter contained allegations about CPL's deteriorating financial condition and poor operating practices. The letter also mentioned that CPL had lost a number of major lawsuits during 1987 and that the insurer's surplus might be below the minimum amount required by law.

In September 1988, the department's financial analysis division noted CPL was voluntarily liquidating itself and looking for a buyer. The division's staff recommended CPL be periodically monitored if a conservation order was not issued.

In March 1989, the department received another letter that repeated the earlier allegations concerning CPL's worsening financial condition. The letter further alleged that the owner of CPL was under investigation for misuse of funds and other violations of federal laws.

In April 1989, during another special examination of CPL, the department found CPL had pledged more than $520,000 of its cash to collateralize loans made to its parent. The department would not accept this amount as a valid asset during the examination. In addition, the department also found CPIS had issued two promissory notes totaling approximately $600,000 to CPL. The department's examiner found CPL did not require any collateral from CPIS to ensure repayment on the two notes. Furthermore, the fact that CPL had pledged more than $520,000 to collateralize loans made to CPIS led the examiner to conclude that it was unlikely CPIS would pay off the notes. Because of the financial condition of CPIS and because the notes were not collateralized, the examiner did not accept the two notes as valid assets.

The court appointed the former commissioner as conservator of CPL in May 1989 after the department determined CPL was insolvent with a negative capital and surplus balance of more than $1.4 million as of February 28, 1989. In August 1989, the former commissioner began proceedings to liquidate the company. Correspondence in the department's files indicate that, as of January 1991, CPL's liquidator had determined that CPIS owed CPL more than $200,000 for misappropriated premiums and another $65,000 for the overcharging of management fees.

The department first questioned CPL's affiliate transactions during its examination completed in April 1983. In addition, the department initiated an investigation of CPL, its parent company, and owners in June 1983. The investigation indicated that the owner of the holding company that controlled CPL profited personally at a time when the financial status of his businesses, including CPL, was in doubt. The investigation report was completed in July 1984. However, based on our review of the files on CPL, we found no evidence of the department taking further action. To the contrary, we could find no indication that the information contained in the investigatory report was even shared with other divisions within the department, such as the financial analysis and field examination divisions, as an aid to those divisions' efforts in monitoring CPL. Furthermore, in its holding company filing covering 1986 and filed in 1987, CPIS and CPL disclosed that the insurer had collateralized loans to the parent company amounting to more than $550,000. These loans were disallowed as valid assets by examiners in their special examination that found CPL to be insolvent with a negative capital and surplus balance of more than $1.4 million as of February 28, 1989. However, based on our review of the department's files on CPL, the department did not question the loan transactions when they were reported more than two years earlier.

California Standard Indemnity

California Standard Indemnity

State of Domicile: California
Net premium written in 1984: $4.8 million
Status: liquidated October 1985

Hazardous Conditions Exhibited		Year First Noted
Questionable investments	☐	
Improper reinsurance	☑	1984
Improper affiliate transactions	☐	
Reserve deficiencies	☑	1985
Poor underwriting	☐	
Poor use of managing general agents	☐	
Agents' high balances	☑	1983

The factors that eventually led to the failure of California Standard Indemnity (California Standard) were improper reinsurance, reserve deficiencies, and a high balance for agents. While the California Department of Insurance (department) was able to detect these hazardous conditions before California Standard's failure, it did not ensure that California Standard took prompt and effective action to correct them. Following is a detailed presentation of those factors leading to California Standard's failure.

Improper Reinsurance

The department had concerns about California Standard's reinsurance agreements by September 1984 when the department sent a letter to California Standard questioning two transactions involving the company's reinsurers. Specifically, the department was concerned that California Standard did not withhold funds

from one of its reinsurers and that the other reinsurer did not report the company as its ceding insurer on its corresponding reinsurance schedule. However, we could not find any evidence the department contacted the company to follow up on either of these issues.

Approximately nine months later, in June 1985, the department's financial analysis division requested that the department's field examination division conduct an examination of the company. The financial analysis division made this request because it found that the company's 1984 annual financial statement indicated the company had unauthorized reinsurance in an amount that would make the company statutorily insolvent. Furthermore, the department had received information from a former employee of California Standard that the company was experiencing financial difficulty. In June 1985, following the financial analysis division's request, the field examination division began an examination of California Standard that covered December 31, 1982, through June 30, 1985. Further, at about the same time, the department's review of California Standard's March 31, 1985, quarterly financial statement indicated the company had several problems including unauthorized reinsurance, excessively high net written premiums, an excessively high balance for agents, and inadequate capital and surplus. The department examiner doing the analysis of the March quarterly statement also noted that California Standard's capital and surplus had fallen below the $1 million required to transact insurance in California without taking into account the consequences of the insurer's unauthorized reinsurance or uncollectible agents' balance. Subsequently, the department found that California Standard admitted that its filed March 31, 1985, quarterly financial statement was not reliable.

In July 1985, the financial analysis division recommended a former commissioner issue a cease-and-desist order against California Standard. The division recommended this action because the company's December 31, 1984, surplus of approximately $900,000 did not meet the required statutory minimum amount of at least $1 million in California and the company also reported more than $2.4 million in unauthorized

reinsurance as of that date. In addition, the department's examination of California Standard as of June 30, 1985, had to be delayed because of the complete disarray of the company's books and records.

On August 5, 1985, the department issued a cease-and-desist order against California Standard. Subsequently, the department completed its examination of the company and found the company was insolvent by approximately $5.5 million. The department's examiners did not accept approximately $2.2 million of the amount California Standard showed as due from reinsurers for loss payments. A former commissioner was appointed conservator of the company on September 6, 1985.

The department knew of reinsurance problems at California Standard for more than ten months before finding the insurer insolvent. In its final examination report, the department determined California Standard was insolvent by $5.5 million, more than $2 million of which represented improper reinsurance.

Reserve Deficiencies

The department took prompt action after it found California Standard had a loss reserve deficiency. (Loss reserves are funds insurers hold for the payment of present and future losses.) In May 1985, the NAIC's report on California Standard's financial ratios for 1984 showed the company had an unusually high estimated current reserve deficiency to surplus ratio. According to the NAIC handbook on ratio interpretation, an estimated current reserve deficiency is the difference between the estimated reserves required by the company and the actual reserves maintained.

In June 1985, the department reviewed California Standard's March 31, 1985, quarterly financial statement and noted that in addition to reporting unauthorized reinsurance and a high balance for agents, the company had nearly a $360,000 reserve deficiency. This reserve deficiency decreased California Standard's capital and surplus by more than $400,000 and rendered the company

statutorily insolvent. On August 5, 1985, the department issued a cease-and-desist order against California Standard, and on September 6, 1985, the department placed the company into conservatorship.

Agents' High Balances

The department first had concerns about California Standard's agents' balances in October 1983 when the department completed an examination of the company for the period ending December 31, 1982. The department recommended the company maintain records of the premiums written by its managing general agent in sufficient detail for calculating the company's unearned premiums for examination purposes. (At the expiration of an insurance policy or contract, the entire premium has been earned. At any point before expiration, the insurer is required to establish a pro rata portion of the premium as a liability account to cover the remaining policy term. The insurer's total unearned premium represents the unearned premium liability for all policies in force.) However, during our review we could not find any evidence the department had taken any steps to ensure that its recommendation regarding the recording of premiums had been implemented.

Approximately seven months later, in May 1984, the NAIC's report on California Standard's financial ratios for 1983 indicated the company had a high ratio for agents' balance to surplus. This ratio measures the degree to which the solvency of an insurer depends on an asset that frequently cannot be readily collected. In July 1984, the department reviewed California Standard's March 31, 1984, quarterly financial statement and found the company had problems in several areas including a high balance for agents. The department questioned California Standard about these problems, and the company indicated it was taking actions to correct them. The department's examiner who reviewed the financial statement recommended the department review California Standard's June 30, 1984, quarterly financial statement to determine the effects of the corrective actions on the company's financial condition. However, we did not find any evidence the department conducted this review.

Ten months later, in May 1985, the NAIC's report on California Standard's financial ratios for 1984 indicated the company had six unusual ratios, including a high ratio for agents' balance to surplus. In June 1985, the NAIC recommended California Standard be targeted for regulatory attention, in part, because of the agents' high balance.

Also, in June 1985, the department's review of California Standard's March 31, 1985, quarterly financial statement showed that the company still had problems in many key areas including liquidity problems due to its agents' high balance.

Further, in June 1985, the department began an examination of the company for December 31, 1982, through June 30, 1985. As a result of the examination, which was completed in August 1985, the department disallowed approximately $2.1 million in the agents' balance because the company was unable to provide adequate detail to support the amount reported as being due from agents.

Beginning in October 1983, the department had concerns that California Standard's recordkeeping was improperly affecting the amount shown in its agents' balance account. Although the department recommended the company maintain more detailed records regarding the unearned premiums its managing general agents reported, the department did not take the steps necessary to ensure California Standard effectively implemented its recommendation. In fact, the department had to delay the completion of its examination of California Standard as of June 30, 1985, because the company's records were in complete disarray, including the records supporting the agents' balance. Furthermore, in 1984 and again in 1985, both the NAIC's and the department's reviews of California Standard's financial statements noted that the agents' balance was an area of concern. Despite these warning signs, the department failed to ensure California Standard took effective action to correct the problem. As a result, the department found that, by August 1985, California Standard's records were so poor that examiners were unable to substantiate approximately $2.1 million of amounts due from the company's agents.

Coastal Insurance Company

Coastal Insurance Company

State of Domicile: California
Net premium written in 1987: $0.063 million
Status: liquidated March 1989

Hazardous Conditions Exhibited		Year First Noted
Questionable investments	☐	
Improper reinsurance	☐	
Improper affiliate transactions	☑	1987
Reserve deficiencies	☐	
Poor underwriting	☑	1986
Poor use of managing general agents	☐	
Agents' high balances	☐	

The California Department of Insurance (department) placed Coastal Insurance Company (Coastal) into conservatorship in February 1989 and into liquidation in March 1989. The factors that eventually led to the failure of Coastal were improper affiliated transactions and poor underwriting practices. While the department was able to detect these hazardous conditions well before Coastal's failure, it did not ensure that Coastal took prompt and effective action to correct them. Following is a detailed presentation of those factors leading to Coastal's failure.

Improper Affiliate Transactions

The department first detected problems in Coastal's dealings with its affiliates during a field examination completed in July 1987 covering the three years ended December 31, 1986. Department examiners found that Coastal had failed to make required filings

and disclosures under the California Holding Company Act. Specifically, Coastal did not file its annual supplementary registration statement required for 1985. The purpose of the annual registration statement is to inform the department of changes in management, ownership, or control of the insurer. In addition, depending on the aggregate amount, certain other insurer transactions require reporting after the fact or need prior approval before the transaction is completed, but Coastal did not always report such transactions or seek the necessary approval.

For example, the examiners noted Coastal violated the Holding Company Act when it failed to disclose in its 1986 annual registration statement an agency agreement entered into in 1986 in which Coastal guaranteed the performance of its affiliate to a third party and was, therefore, liable if the affiliate defaulted. In addition, the examination report mentioned that Coastal was receiving a variety of services from its parent company under an unwritten management agreement. The parent was providing services for Coastal such as accounting, underwriting, premium financing, investing, claims adjusting, and reserving. In exchange for these services, Coastal was paying the parent company commissions amounting to 25 percent of the premiums earned and 97.5 percent of the policy fees earned for Coastal by the parent company. Coastal was also paying the parent company for unallocated loss adjustment expenses representing 6 percent of the premiums the parent earned for Coastal. Finally, the examiners stated Coastal had advanced funds to its parent company and affiliates during 1986 in sufficient amounts so as to have required the former commissioner's prior approval, which Coastal did not obtain. Coastal's advances to its parent company and affiliates during 1986 amounted to more than $1.8 million. The examiners did not allow these advances to be shown as an asset in determining the financial condition of Coastal, stating that such advances were unsecured.

Moreover, neither the details concerning Coastal's unwritten management agreement with its parent company, nor the advances Coastal made to its parent and affiliates were disclosed in the insurer's annual registration statement filed for 1986. This failure

to disclose was in violation of the California Holding Company Act. Furthermore, during 1987, Coastal continued to advance funds to its affiliates. The examiners, reporting on events occurring after the statement date of December 31, 1986, noted that the balance for affiliate advances had grown to more than $3.9 million as of the end of February. However, unlike the advances made during 1986, Coastal did report the advances made during 1987 in its annual registration statement covering 1987.

The department did not inquire about Coastal's affiliated transactions again until a year later, in July 1988, when the department's legal counsel requested more information from Coastal concerning the affiliated transactions mentioned in the examination report. Part of the request required additional clarification concerning the types of services Coastal's parent company was providing and how much Coastal was paying annually for those services. The counsel added that the department was not in favor of service agreements that advance affiliates funds in excess of Coastal's actual costs. In addition, the department's counsel requested that Coastal file all registration statements and disclosures the Holding Company Act required to avoid potential violations.

In his response to the department, Coastal's legal counsel indicated that in addition to the services described in the examination report, the parent provided sales and clerical support services to Coastal. Furthermore, Coastal's response stated that the parent company had 1,000 employees who performed insurance-related services for Coastal since Coastal had few employees of its own. The counsel for Coastal also stated that, as of April 1988, the company had made the required filings and disclosures. Also in 1988, Coastal's legal counsel responded to the department's 1986 examination criticisms by stating that the affiliate advances the department did not allow represented annual commissions paid to affiliates for business they would generate throughout the year. Coastal's counsel went on to explain that the advances were meant to pay for the annual expenses the affiliates would incur in producing business for Coastal. However, the counsel also stated that such business was in the nature of monthly policies for which

the affiliates collected monthly premiums. In effect, we conclude Coastal was advancing payments on expenses its affiliates had not fully incurred yet and might never incur if the policies they were writing were not renewed each month. The legal counsel for Coastal further stated that these types of advances were common within the industry and that Coastal did not feel this practice violated any requirements of the California Holding Company Act. However, to avoid any potential problems, Coastal agreed to discontinue the practice of advancing commissions to its parent company and further believed that all outstanding commission advances would be repaid by March 15, 1988.

Although Coastal promised the department it would discontinue making advances to its affiliates and all such advances would be repaid, the department found out later that Coastal had not kept these promises. Because of its mounting concerns about Coastal's solvency, the department conducted a special examination beginning in November 1988 for the period ended September 30, 1988. The special examination was completed in February 1989, and examiners found that rather than curtailing the practice of making advances to its affiliates, Coastal had instead made a number of additional advances. The examiners reported that, during 1988 alone, Coastal had advanced more than $66 million to one of its affiliates. However, as of September 30, 1988, the amount due from affiliates was approximately $26 million. Furthermore, the examiners stated that all of the advances Coastal made to one of its affiliates during 1988 were in violation of the California Holding Company Act because Coastal neither reported the advances nor obtained prior approval, as was required for advances of such magnitude. As a result of the special examination, examiners refused to recognize the entire $26 million in unsecured advances due from Coastal affiliates.

The department is currently pursuing a civil lawsuit against the former officers and directors of Coastal for numerous violations of the California Holding Company Act and federal racketeering laws. In the lawsuit, the department contends that Coastal diverted more than $49 million to its parent company and affiliates through the use of advances. Of this amount, Coastal advanced more than

$29 million to its parent company alone between October 1988 and January 1989. Furthermore, the lawsuit states that these advances were never memorialized in the form of promissory notes, loan agreements, or other formal documents. Finally, the suit contends that the advances Coastal made were not secured, did not provide for the payment of interest, and did not have any fixed repayment schedules. The suit alleges that as a direct and proximate result of Coastal's violations of the Holding Company Act, those affected by Coastal's estate have suffered losses exceeding $66 million.

The department first detected problems involving transactions between Coastal and its affiliates in 1987. Subsequently, the department attempted to informally resolve the department's concerns about the advances Coastal was making to its affiliates. However, this course of action proved futile, and in 1989, almost two years later, the department conserved Coastal. A main reason why the department decided to conserve the company was that department examiners found $26 million in unsecured advances due from Coastal's affiliate.

Poor Underwriting

Coastal was a wholly owned subsidiary of Advent Management Corporation (AMC). AMC, in turn, was owned by Advent Company. AMC served as Coastal's managing general agent. Such agents perform a variety of insurance-related services including underwriting, premium financing, and claims reserving and adjusting. In October 1985, AMC acquired ownership of Public Insurance Services (Public). In January 1986, AMC, doing business as Public, began issuing automobile liability policies to high-risk drivers in Coastal's name. These developments were significant because not only was Coastal changing the way it underwrote its insurance products, but it was also providing its insurance products to a new, high-risk market. It can be hazardous when an insurer changes the way it markets its products or changes the group it markets its products to. One danger is that the insurer will suddenly increase its underwriting volume without a sufficient amount of surplus to protect against the increase in losses

associated with the increase in business written. The other danger is that the insurance premiums charged may not reflect the new types of risks being underwritten. The fact that this change in Coastal's underwriting concerned the department became evident in a memorandum written in April 1986 by an examiner from the financial analysis division. The examiner requested that Coastal's field examination date be moved up as a result of the company underwriting a significant amount of new auto liability business through Public, acting as its agent. However, the field examination of Coastal did not begin until April 1987, a year later.

An examination report for Coastal was completed in July 1987 covering the three years ended December 31, 1986. In a section of the report commenting on events occurring after this three-year period, the department's examiners noted that, during the first two months of 1987, Coastal's affiliates acquired two insurance agencies. The examiners concluded that, during 1987, Coastal had shifted away from using independent agents to become a direct underwriter through Public and its two new affiliates, FGS Insurance Agency (FGS) and Warschaw Insurance Agency (Warschaw). In October 1987, an examiner from the financial analysis division noticed that Coastal's automobile casualty business had increased and that the casualty operations seemed marginal. The examiner recommended closely watching any developments from Coastal's casualty business.

In March and April 1988, the department performed a market conduct examination of Coastal to investigate complaints involving the insurer's handling of insurance claims. During a market conduct examination, examiners may inspect the insurer's claim documents and processing procedures to ensure that the insurer fulfills its lawful obligations to policyholders filing claims. The examination was prompted by a 287 percent increase in the number of complaints the department received in 1987 involving Coastal. The results of the market conduct examination revealed pervasive shortcomings in Coastal's ability to handle its auto claims properly. The department's examiners sampled 462 automobile claim files and found errors in 185 for an overall error rate of 40 percent. Examiners cited problems including delays in the processing and

payment of claims, insufficient documentation in claim files, and inadequate reserving. The department instructed Coastal to submit, within 15 days, a written response outlining its planned corrective action to address the examiners' findings. Examiners also informed Coastal that, because of the high error rate, the department would conduct a follow-up examination in six months. Finally, the department warned Coastal that, unless significant improvements were found at that time, the department would proceed with more formal actions authorized by law.

Also, in April 1988, the department, in conjunction with the market conduct examination, performed an underwriting examination of Coastal. Some of the factors the examination criticized Coastal for were its failure to provide adequate service to clients, its failure to provide the department with prompt and fully responsive answers to inquiries, its failure to exercise reasonable control over one of its general agents, and its failure to make full disclosures in its dealings with its clients. The examiners concluded that, among insurers marketing personal automobile lines of coverage, Coastal ranked in the lowest 7 percent for 1987. In addition, over two years, Coastal had experienced an increase in complaints, and the trend appeared to be worsening. As in the market conduct examination, the department instructed Coastal to respond to the findings included in the report within 15 days. However, the department failed to pursue any formal regulatory action against Coastal even though the two examinations' results should have been sufficient warning to the department about the precarious nature of Coastal's claims practices and financial condition.

In September 1988, after reviewing Coastal's June quarterly statement, one of the department's examiners found Coastal had a $9 million deficiency in its loss reserve and was writing premiums at an annualized volume of seven times its surplus, a volume considered unacceptable. Both the National Association of Insurance Commissioners (NAIC) and the department use the benchmark of three as the definition of a prudent ratio of premiums written to surplus. If an insurer exceeds this benchmark, its surplus may not be sufficient to absorb above average losses associated

with the premiums it is writing. In his letter to Coastal's president, the examiner stated that the department was very concerned about Coastal's financial stability and believed a $10 million cash infusion was imperative to avoid further regulatory action.

In October 1988, the department performed a follow-up to the market conduct examination completed in April. The department's examiners found the same problems as those cited in the first market conduct examination. Moreover, the department's examiners concluded that the overall quality of Coastal's claim handling had deteriorated since the first examination. Further, in November 1988, one of the department's examiners advised the legal division to deny a pending application from Coastal to underwrite additional lines of insurance or request Coastal to withdraw the pending application. The examiner cited among his reasons for denial the fact that Coastal had claims and underwriting problems and was overextended in its underwriting capacity.

In December 1988, the department began another examination of Coastal's rating and underwriting practices. However, the department never completed it. According to an unfinished draft report, the department found Coastal did not always use established underwriting guidelines. For instance, the examiners found that for a Mexican trucking line of business, the agent set the insurance rates solely through judgment. In addition, the department's examiners could not conduct the usual study of the loss and expense experiences for the previous three years because neither Coastal nor the department was able to locate important data necessary for the study.

In February 1989, the department completed a special field examination of Coastal. The department's examiners noted that the amount of premiums Coastal earned had grown from approximately $9 million in 1986 to approximately $85 million by September 30, 1988. Moreover, during the nine months ending September 1988, Coastal sustained a net underwriting loss of approximately $26 million. Subsequently, the department concluded through its examination that Coastal was insolvent by approximately $47 million.

After the department issued a conservatorship order in February 1989, it formed a task force to investigate the circumstances behind Coastal's insolvency. The task force ultimately determined that Coastal did not use any underwriting guidelines. This failure to use guidelines contributed to Coastal's underwriting losses. Specifically, the department found that, from January 1986 through December 1988, Coastal had increased its share of the substandard automobile liability market in California through drastic and rapid growth. Coastal's premiums increased from approximately $13 million to approximately $144 million during those three years, with approximately $113 million in premiums written in 1988 alone. During those same three years, Coastal suffered major underwriting losses. For example, during 1987, Coastal reported a net underwriting loss of approximately $46 million. In addition, from January to September 1988, Coastal sustained another net underwriting loss of approximately $26 million.

The department is currently pursuing a civil lawsuit against the former officers and directors of Coastal for numerous violations of the California Insurance Code and federal laws. In the lawsuit, the department contends that Coastal ignored and circumvented recognized underwriting principles, sales practices, and the requirements of California laws for the prudent management of an automobile liability insurance business. The department found that Coastal disregarded basic underwriting standards by falsifying customer applications so that lower premiums could be charged, thereby enabling applicants to qualify for insurance.

Despite negative information from financial reviews in April 1986, a field examination completed in July 1987, two market conduct examinations in April and October 1988, and an underwriting examination in May 1988, the department allowed Coastal to continue operating until February 1989, thereby, endangering more policyholders and allowing the financial condition of Coastal to further deteriorate. However, the department did not take any formal regulatory action against Coastal. Because of Coastal's poor underwriting practices, the company sustained an underwriting loss of approximately $26 million. This loss contributed to its insolvency of approximately $47 million.

Colony Charter Life Insurance Company

Colony Charter Life Insurance Company

State of Domicile: California
Net premium written in 1986: $10.3 million
Status: liquidated May 1987

Hazardous Conditions Exhibited		Year First Noted
Questionable investments	☐	
Improper reinsurance	☑	1984
Improper affiliate transactions	☑	1984
Reserve deficiencies	☐	
Poor underwriting	☐	
Poor use of managing general agents	☐	
Agents' high balances	☐	

The California Department of Insurance (department) placed Colony Charter Life Insurance Company (Colony) into conservatorship in January 1987 and into liquidation in May 1987. The factors that eventually led to the failure of Colony were improper reinsurance and improper affiliated transactions. While the department was able to detect these hazardous conditions well before Colony's failure, it did not ensure the company took prompt and effective action to correct them. Following is a detailed presentation of those factors leading to Colony's failure.

Improper Reinsurance

The department had concerns about Colony's reinsurance contracts as early as April 1984. After reviewing Colony's 1983 annual statement, a department examiner questioned the company's treasurer about a reinsurance agreement Colony had entered into

with a reinsurer not admitted in California. The examiner believed that, according to the information contained in Colony's annual statement, the company failed to meet the requirements contained in the Insurance Code allowing an insurer to reduce its reserves relating to the business it cedes to nonadmitted reinsurers. According to Section 922.4 of the California Insurance Code, for an insurer to reduce its estimated liability for losses associated with business ceded to a nonadmitted reinsurer, the primary insurer must prove to the insurance commissioner that the nonadmitted reinsurer meets the financial requirements and maintains the same standards of an insurer licensed to do business in this State. In lieu of demonstrating such proof, the code allows the primary insurer to withhold funds or obtain letters of credit from nonadmitted reinsurers in amounts equal to the estimated losses associated with the ceded insurance. According to the department, Colony had reduced its reserves by more than $446,000 in connection with business it had ceded to one such nonadmitted reinsurer. The department requested that Colony provide specific information to justify Colony's reduction of its reserves.

Colony responded to the department's request in May 1984 by sending a copy of its reinsurance agreement with the nonadmitted reinsurer. Colony also sent a copy of the trust agreement covering the securities withheld from the reinsurer that were intended to guarantee payment to Colony on the business reinsured. After receiving the materials Colony sent, the department's examiner apparently still had reservations concerning the reinsurance arrangement because, in June 1984, she requested that examiners conducting the field examination of Colony for the period ending December 31, 1983, determine whether the securities held in trust were admissable assets.

In August 1984, a member of the department's legal counsel summarized the results of a meeting held between Colony's management and department representatives. According to that summary, the department's examiners, who were then conducting the examination of Colony, stated they might disallow the reduction in reserves Colony made as a result of its reinsurance. Colony's actuary indicated in the meeting that he was in the process of revising Colony's reinsurance contracts to conform with the department's requirements.

However, there seems to have been a difference of opinion among the examiners responsible for monitoring Colony during this period. Specifically, another examiner working in the department's reinsurance bureau made no negative comments after performing an analysis of Colony's reinsurance contracts in October 1984.

Moreover, when the department examiners completed their examination report of Colony in December 1984, the department examiners did not require Colony to increase its reserves to compensate for the problems they identified with the reinsurance agreement they began to question in April 1984. Colony was not required to increase its reserves even though the examiners found that the reinsurance agreement failed to comply with the department's regulations in three areas. First, under Colony's custodial bank agreement, securities obtained to ensure performance were held jointly by the reinsurer and Colony. It was the department's position that all such securities be solely in the name of the ceding company, Colony. Second, the securities the reinsurer offered were shares of stock in its affiliates. The department held that these shares were not acceptable as liquid deposits because Colony could not demonstrate to the examiners that the shares could be freely traded on any stock exchange or that the shares' value could otherwise be substantiated. Third, the promissory notes Colony obtained from the reinsurer and placed in deposit were not assigned to Colony. The report noted that Colony had promised to correct all the deficiencies noted.

After reviewing the securities custody trust agreement between Colony and this same nonadmitted reinsurer in June 1985, the department's legal counsel wrote to Colony's president objecting to many of the sections contained in the agreement. These objections resulted in the department's decision to reject the reduction Colony made in its 1984 statement of reserves to reflect the business ceded to the reinsurer. In closing his letter, the department's counsel did offer Colony 40 days in which to revise the trust agreement to conform with the California Insurance Code so that Colony would not have to increase its reserves. However, Colony did not take advantage of the department's offer.

Almost a year later, in May 1986, the department's counsel again wrote to Colony's president to inform him that the department had received no response to his June 1985 letter concerning the trust agreement between Colony and one of its reinsurers. As a result, the department again rejected any reduction in Colony's 1985 statement of reserves to reflect the business ceded to this reinsurer. The letter also informed Colony's president that, if and when the trust agreement was revised, the department would reconsider whether to allow Colony to reduce its reserves for the business it reinsured.

Colony's vice president finally responded to the department in late May 1986 explaining various sections of the trust agreement and offering to revise or amend other sections that the department had objected to. Further, in July 1986, Colony informed the department that the company had entered into a second reinsurance arrangement with another nonadmitted reinsurer during 1985. In response to the department's request, Colony sent copies of the reinsurance and trust agreements pertaining to this new reinsurer to the department in August 1986.

In July 1986, one of the department's examiners recommended issuing a cease-and-desist order against Colony, in part, because of its unauthorized reinsurance. This recommendation came after the examiner had reviewed Colony's quarterly statement dated March 1986. The examiner noted that the reinsurance problem had been brought to Colony's attention during the department's 1983 examination of the company, but Colony had yet to correct it. However, we found that the department did not issue the order at that time.

In September 1986, the department's legal counsel wrote to Colony's counsel concerning the reinsurance arrangements with both of the nonadmitted reinsurers previously discussed. The counsel, who had the opportunity to review not only the trust agreements but also the reinsurance agreements for both reinsurers, raised additional questions. He questioned whether one of the reinsurance agreements was, in effect, a "fronting" arrangement where Colony retained no risk. A fronting arrangement allows

companies that are unlicensed (nonadmitted) in a state to transact business without regulatory oversight. The department also questioned apparent inconsistencies within the two reinsurance agreements and trust agreements and asked what Colony's actual intent was in the operation of both of the reinsurance agreements. These questions were of a serious enough nature that the department's counsel informed Colony's counsel the department would not allow Colony to reduce the amount of its reserves to reflect either of its reinsurance agreements with these two nonadmitted reinsurers. The counsel further stated that he was aware of the effect the department's refusal would have on the insurer's statutory solvency. The letter recommended that Colony research the shortcomings in the reinsurance and trust agreements and redraft the agreements accordingly.

In late December 1986, Colony's counsel wrote to the department's counsel proposing solutions to the department's concerns about Colony's reinsurance agreements. However, in his response in January 1987, the department's counsel advised Colony that until it revised both reinsurance agreements and the trust agreement to the department's satisfaction, no reduction in reserves relating to the business reinsured under these agreements would be allowed.

Also, in January 1987, the department completed its special examination of Colony as of June 30, 1986. The examination initially found Colony to be insolvent by almost $500,000. The department then updated its examination of Colony through September 30, 1986. As of that date, Colony's insolvency had grown to more than $2.7 million. The department's examiners stated in the report that Colony's reinsurance agreements with the two nonadmitted reinsurers contained various inconsistencies and questionable contractual provisions. The department's rejection of these two reinsurance agreements alone would have resulted in Colony being insolvent.

As early as April 1984, the department found problems with Colony's reinsurance agreements. However, based upon our review, the department did not take any formal regulatory action at

that time. Instead, the department relied on Colony's promises that it would take the steps necessary to comply with the requirements in the California Insurance Code relating to reinsuring business with nonadmitted reinsurers. In addition, there seemed to be a difference of opinion within the department concerning the validity of one of Colony's reinsurance agreements. On one hand, examiners conducting the 1983 field examination pointed out various problems with one of Colony's reinsurance agreements in August and again in December 1984. On the other hand, an examiner in the reinsurance bureau, who had reviewed Colony's reinsurance agreements in October 1984, found no problems.

Improper Affiliate Transactions

As early as April 1984, the department found problems in Colony's transactions with its affiliate. However, the department had been concerned about the potential for abuse of transactions between Colony and its affiliate as early as May 1982 when Blake Holding Company, which later became Colony's parent company, sought to purchase Colony. At that time, the department suspected that Blake Holding Company did not have the financial resources necessary to purchase Colony. The department believed the owner of Blake Holding Company might try to take money out of Colony to pay for a loan he proposed to use to buy Colony. In fact, the department initially denied Blake Holding Company's application to purchase Colony on the grounds that the financial condition of the acquiring person might jeopardize the financial stability of Colony or prejudice the interests of its policyholders. However, the owner of Blake Holding Company was able to convince the department that he had sufficient income from his real estate and other business holdings to service the proposed loan amount. In addition, Blake Holding Company's owner pledged to the department not to let Colony's surplus fall below $3.7 million while any part of the loan was outstanding. Despite its earlier concerns, the department rescinded its earlier denial and allowed the Blake Holding Company to purchase Colony in May 1982.

Then, in April 1984, the department found that, during 1983, Colony had paid dividends to Blake Holding Company in amounts large enough in the aggregate to require the prior approval of the commissioner according to the California Holding Company Act. However, Colony did not seek such approval. Because Colony did not seek this approval, the department's legal counsel concluded that Colony had violated the Holding Company Act and the parent company was illegally taking money out of Colony. The department's legal counsel and the chief of the financial analysis division both recommended ordering Colony's president, who also owned Blake Holding Company, to return the illegally paid dividends to Colony.

Between April and September 1984, department officials informally negotiated with Colony and its parent company in an attempt to retrieve the illegally paid dividends. These negotiations consisted of correspondence between the department and Colony as well as meetings attended by representatives of both parties. According to one of the department's legal counsels, during one such meeting in August 1984, the owner of Blake Holding Company admitted that without the ability to use dividends paid from Colony to service the debt of Blake Holding Company, the bank where he financed his purchase of Colony would call his loan. The department's counsel asked why the owner of Blake Holding Company did not use the other sources of income he had pledged at the time he purchased Colony to service the loan. The owner of Blake Holding Company claimed that, because of recent highway closures near his property, his Malibu real estate was not producing enough income to pay the interest on the loan. Colony submitted a request dated the same day as the meeting asking for a former commissioner's approval to pay a $346,000 dividend, which the department later denied. In its denial letter, the department stated it was still considering what action would be taken regarding the more than $1 million in dividends Colony paid illegally to the Blake Holding Company between March 1983 and April 1984.

In October 1984, the department decided that if Colony limited future dividends, it would have sufficient surplus to meet its estimated needs without returning the previously paid dividends. Consequently, in March 1985, when the owner of Blake Holding Company again requested a former commissioner's approval to pay an $850,000 dividend, his request was denied.

Almost a year later, in April 1986, a department examiner found Colony had once again violated the California Holding Company Act in late 1985 by making loans to its parent company and affiliate in excess of the limit established by law. The examiner stated that the owner of Blake Holding Company, having been denied approval to pay an $850,000 dividend, found another way to take money out of Colony by way of affiliate loans amounting to more than $708,000. As with Colony's previous violations of the Holding Company Act, Colony had not sought the required prior approval from the department. The examiner also noted that the owner of Blake Holding Company had failed in both 1984 and 1985 to adhere to the commitment he made when he purchased Colony of maintaining a surplus amount of at least $3.7 million.

In addition, after reviewing Colony's March 1986 quarterly statement, the same examiner noted that an additional illegal loan was made to Blake Holding Company in the amount of approximately $149,000. The examiner recommended to the chief of the financial analysis division that the department issue a cease-and-desist order against Colony. The chief advised the owner of Blake Holding Company on July 16, 1986, that, unless $850,000 were returned to Colony or a viable plan for selling the company was presented within two weeks, the department would have no choice but to issue a cease-and-desist order. However, when Blake Holding Company's owner neither returned the money nor provided a plan for selling the company by the department's deadline, the department failed to issue such an order. Only two months later, the department examiner reviewing Colony's June 1986 quarterly statement again found that the company had made another illegal loan of $92,000 to Blake Holding Company.

In January 1987, after completing a special field examination, the department's examiners would not recognize as a valid asset $2 million that Colony had shown as "funds in transit" on its September 30, 1986, financial statement. According to the department's report, Blake Holding Company was to have supplied the funds to pay off an intercompany loan of approximately $560,000, and the remaining $1.44 million was intended to be a cash contribution to Colony's surplus. However, the examiners stated that the $2 million from Blake Holding Company never materialized. As a result, the examination found Colony to be insolvent by $2.7 million as of September 30, 1986.

In January 1991, the department filed a civil lawsuit against Blake Holding Company and its owner in an attempt to recover the money diverted out of Colony through the illegal payments of dividends and loans to an affiliate.

The department was concerned about the potential for abusive transactions between Colony and its parent company as early as 1982. In subsequent years, Colony made numerous illegal and improper affiliate transactions, but based upon our review, the department took no formal regulatory actions against the company. Five years later, in 1987, the department declared Colony insolvent by $2.7 million, with $2 million of that amount representing funds due from Colony's parent company.

Executive Life Insurance Company

Executive Life Insurance Company

State of Domicile: California
Net premium written in 1989: $637 million
Status: conserved April 1991

Hazardous Conditions Exhibited		Year First Noted
Questionable investments	☑	1980
Improper reinsurance	☑	1980
Improper affiliate transactions	☑	1979
Reserve deficiencies	☑	1978
Poor underwriting	☐	
Poor use of managing general agents	☐	
Agents' high balances	☐	

The factors that eventually led to the failure of the Executive Life Insurance Company (ELIC) were questionable investments, improper reinsurance, improper affiliate transactions, and reserve deficiencies. While the California Department of Insurance (department) was able to detect these hazardous conditions well before ELIC's failure, it did not ensure that the company took prompt and effective action to correct them. Following is a detailed presentation of those factors leading to ELIC's failure.

Questionable Investments

On April 11, 1991, the California insurance commissioner found ELIC to be operating in a hazardous manner and placed it under conservatorship. In his statement to the United States Committee on Commerce, Science, and Transportation, given on May 7, 1991, the commissioner cited ELIC's investments in high-

yield non-investment grade bonds, commonly known as "junk bonds," as one of the main determinants in his move to conserve the company. Investments in too many of these high-yield bonds can mean a company has too much risk to completely cover. These bonds are rated "non-investment" according to the grades established by Standard & Poor's, which rates bonds according to their investment worth. The "non-investment" grade falls below the four highest grades Standard & Poor's uses.

Although the department did not conserve ELIC until 1991, it began to have questions regarding ELIC's investments as early as 1980. Specifically, through a review of the company's financial statements, a department examiner noted that ELIC's premium volume had increased from $95 million at December 31, 1979, to more than $300 million at June 30, 1980, and according to information obtained from ELIC was derived primarily from annuities. An annuity is an insurance product investment for which a person receives fixed payments over a set period of time. The sale of annuities can threaten an insurer's solvency if, for instance, an insurer guarantees a higher rate of return to its annuity policyholders than it is able to earn on the investments it makes. Then the payments could create a drain on the insurer's surplus.

The examiner indicated in August 1980 that the department would question ELIC on the type and nature of these annuities; the interest rates being paid; whether the rates were guaranteed, and if so, for how long; and the type of investment vehicles ELIC was using to fund the annuity payments. However, we could not find any evidence indicating the department ever followed up to get answers to these questions. Further, the National Association of Insurance Commissioners (NAIC), through its analyses of key financial ratios computed from ELIC's 1980 and 1981 annual statements, found that ELIC's change in premium ratio exceeded industry norms by a wide margin during both years. According to the NAIC, such a condition could indicate that the insurer may not have the knowledge and experience required to maintain financial strength while its operations are going through a dramatic change. In 1981, and again in 1982, the NAIC recommended that ELIC be accorded immediate regulatory attention based on its financial

performance in 1980 and 1981. Despite the concerns the department's examiner raised and the recommendations the NAIC made, we could find no documentation of the department placing any extra emphasis on its review of ELIC's practices beyond its normal review of the company's financial statements.

Furthermore, in 1982, a former insurance commissioner received a copy of an anonymous letter written to the enforcement division of the Securities and Exchange Commission alleging ELIC's involvement in securities violations and improprieties in its dealings with Drexel Burnham Lambert, Inc. (Drexel). Drexel is a securities investment brokerage firm ELIC used to buy and sell securities on its behalf. The letter stated that ELIC and another affiliate, Executive Life of New York (ELNY), were depleting their assets as a result of buying securities at highly inflated prices from Drexel's high-yield bond department. These transactions allowed Drexel to earn a profit of more than $30 million over 18 months. The letter further alleged that after selling securities to the insurers at big markups, Drexel would buy back any securities that appreciated in value, thus providing the two insurers with a small profit. However, any securities that depreciated in value would be left in the insurers' portfolios. According to the letter, as a result of this type of trading in junk bonds, both insurers suffered losses and had sizable holdings in at least 12 companies that were bankrupt at that time.

The letter went on to describe examples of alleged improprieties engaged in by Drexel, ELIC, and First Executive Corporation, ELIC's parent company. Even though a former insurance commissioner requested that his staff review the letter and respond to him as soon as possible, we could not find any evidence the department pursued any of the allegations contained in the letter. Furthermore, according to the chief of the financial analysis division, his division's records did not indicate whether the division made any specific follow-up efforts to confirm or deny the letter's allegations or to determine whether the Securities and Exchange Commission investigated the charges contained in the letter.

In December 1984, while conducting an examination of ELIC, the lead examiner of the department's examination team informed the department's chief examiner that one of his staff believed ELIC had overpaid on stock and bond purchases and had been underpaid on the sales of these securities by as much as a quarter of a billion dollars in 1983. However, we could find nothing in the files or in the examination report covering 1983 to prove the department had pursued this issue.

In May 1985, the department completed its report of examination on ELIC covering December 31, 1980, through December 31, 1983. The department's examiners found that ELIC's president controlled ELIC's overall investment philosophy and individual investment decisions. In addition, the report stated that the president was solely responsible for approving all brokers' invoices and that ELIC purchased and sold approximately 90 percent of its securities through one broker, Drexel. The department recommended that ELIC's newly formed internal audit department periodically review ELIC's investment operations because of their importance and structure. The report further recommended that ELIC's board of directors designate a member of the executive committee to share responsibility for approval of brokers' invoices. However, in our review of the subsequent examination of ELIC and other documentation, we found no indication the department confirmed whether those recommendations were ever implemented.

The report also noted that bonds represented 79 percent of total admitted assets at December 31, 1983. Furthermore, almost 60 percent of those bonds, excluding bonds called private placements which are not actively traded on a recognized stock exchange, were rated below Standard & Poor's four highest investment grades. As mentioned earlier, bonds rated below the four highest investment grades are commonly referred to as junk bonds. Finally, the report noted that 13 bonds worth more than $38 million were in default, but because the amount was deemed to be immaterial in relation to ELIC's $2.7 billion bond portfolio, the examiners did not adjust the financial statements.

During the remainder of 1985 up until the next field examination requested by the chief of the financial analysis division in March 1987, concerns about ELIC's investment practices continued to be raised from within the department and from external sources. For example, during his analysis of ELIC's annual statements for 1984 and 1985, a department examiner noted that, for both years, investments were unsatisfactory or unusual. In addition, the department received a letter from the Securities Valuation Office (SVO) of the NAIC in July 1985 stating the SVO had recently completed a review of ELIC's industrial and miscellaneous bonds to verify compliance with the SVO's reporting and valuation standards.

As a result of its review, the SVO found that approximately $203 million of ELIC's bonds were not reported for valuation, $92 million in bonds were not valued by the SVO because of insufficient information, and another $152 million in bonds were valued by ELIC using values other than the ones the SVO established. The letter went on to state that, over the years, the SVO had not had good results in dealing with ELIC, and the company's attempts at compliance were almost always substandard and lacking in documentation. Further, because of the large number of securities acquired by ELIC each year, its noncompliance had become a serious valuation problem for the SVO. The SVO concluded that the annual statement ELIC submitted to the department for 1984 contained many inconsistencies and immediate department action was necessary to bring ELIC into compliance with the SVO's *Valuation of Securities* manual.

In response to the SVO's concerns, the department contacted ELIC's president in October 1985 and instructed him to take immediate corrective action in complying with the SVO's valuations manual. Also, the department instructed him to refile with the department the schedule of bond valuations submitted with ELIC's 1984 annual statement and to carry forward revisions in future filings. After checking ELIC's 1985 schedule of miscellaneous bonds against the SVO's valuations manual, one of the department's examiners concluded that ELIC had substantially

complied with the department's request. Finally, in March 1987, as a result of his analysis of ELIC's annual statements, a department examiner recommended that one of the areas the next scheduled triennial field examination should focus on was ELIC's investment in junk bonds.

In April 1988, the department completed its report of examination of ELIC covering December 31, 1983, through December 31, 1987. However, the report did not indicate that the department's examiners focused their examination on ELIC's junk bonds, as was recommended, nor did it result in any examination adjustments to ELIC's investment accounts. Nevertheless, the department did note that the market value of ELIC's bonds at December 31, 1987, was $312 million less than its book value of $9.1 billion and that junk bonds accounted for 65.3 percent of ELIC's total book value for bonds. In other words, if ELIC were to sell its bond portfolio as of December 31, 1987, it would receive $312 million less than the amortized cost of the bonds. The department further noted that, during 1986 and 1987, ELIC wrote off 41 bonds with a total book value of approximately $142 million and 22 issues of common stocks with a total book value of almost $27 million. Finally, to more clearly disclose the nature of the investment, examiners recommended ELIC reclassify its $131 million contribution to its subsidiary, ELNY, as "investments in subsidiary" instead of "other invested assets" as was originally reported.

According to a department memorandum, in January 1990, ELIC's president announced that First Executive Corporation, ELIC's parent company was reducing the recorded value of its junk bond portfolio by as much as $515 million and that reductions pertaining to ELIC represented approximately $364 million of the total. In response to the announcement, the department began a special examination of ELIC. The examination focused on all ELIC's financial affairs, including the negative effect on cash flow that any increase in policy surrenders and any further decline in the market value of ELIC's security investments would have on the company's surplus. In addition, the NAIC formed a working group to discuss non-investment grade bonds. The group met with

representatives of the First Executive subsidiaries in February 1990 to review the financial results for 1989 relating to insurance operations. In the meeting, the group discussed the various subsidiaries' current financial positions. The group concluded that, in the short term, ELIC and the other subsidiaries had sufficient resources and liquidity.

In March 1990, the department's supervisory insurance examiner of the special examination in progress at ELIC recommended that the department either place ELIC in conservation or make it subject to joint control supervision. The examiner recommended these measures mainly to protect policyholders and to ensure fair and equal treatment for those policyholders surrendering policies. However, the former insurance commissioner did not act on the recommendation. During that same month, the department received the NAIC's synopsis of its review of the 1989 annual statement ELIC filed indicating that ELIC's investment in junk bonds had grown to $6.4 billion as of December 31, 1989.

In April 1990, one of the department's legal counsels noted in a memorandum that ELIC again announced it would have to make further reductions to the value of its investment portfolio. Because of these reductions and a higher than normal rate of policy surrenders, the department monitored the financial status of ELIC daily. In mid-June, the department determined that the market value of ELIC's bonds, as of March 31, 1990, was approximately $1.9 billion less than their book value. Subsequently, the department's review of ELIC's quarterly financial statement for June 1990 showed that ELIC's reserve for losses on securities had decreased $271 million over six months and now amounted to $312 million. The department's examiner concluded the reserve provided little protection relative to the company's weak junk bond portfolio. As a result, the department scheduled an examination of ELIC to begin in October 1990 covering December 31, 1987, through December 31, 1990. In January 1991, the department increased its close monitoring of the company, requiring ELIC to retain consultants to review its asset portfolio, requiring it to submit a five-year business plan, and placing various restrictions on its activities.

In March 1991, the department's review of ELIC's 1990 annual statement showed that the market value of ELIC's bonds, as of December 31, 1990, was approximately $2.2 billion less than their reported statement value. On April 8, 1991, the department's chief of the financial analysis division confirmed in writing to the insurance commissioner that the independent accountants of First Executive Corporation did not express an opinion on the parent company's financial statements because of their substantial doubt about the parent company's ability to continue. Subsequently, on April 10, 1991, ELIC's president informed the insurance commissioner that ELIC may have been impaired as of March 31, 1991, because of a series of bond defaults and adjustments required by regulatory authorities. Finally, on May 10, 1991, the department finished its report of examination of ELIC showing a deficit in the company's surplus of approximately $356 million as of December 31, 1990. Part of the deficit was attributable to ELIC overvaluing its investments in bonds, stocks, real estate, and other assets by more than $461 million.

The department first had concerns about ELIC's investments as early as 1980. Even though the department repeatedly questioned ELIC's investments and investment practices in subsequent years, its regulatory efforts did not prevent ELIC's continued questionable investments, which finally resulted in the company overvaluing its assets by more than $461 million in 1991.

Improper Reinsurance

In the early 1980s, the department and the NAIC, through their separate reviews of ELIC's financial statements, noted potential problems with ELIC's reinsurance activities. Specifically, the department was concerned with the amount of reinsurance ELIC was placing with its affiliates and with nonadmitted reinsurers.

According to Section 922.4 of the California Insurance Code, for an insurer to reduce its estimated liability for losses associated with business ceded to a nonadmitted reinsurer, the primary insurer must prove to the insurance commissioner that the nonadmitted

reinsurer meets the financial requirements and maintains the same standards as an admitted insurer doing business in this state. In lieu of demonstrating such proof, the code allows the primary insurer to withhold funds or obtain letters of credit meeting specific statutory requirements for nonadmitted reinsurers in amounts equal to the estimated losses associated with the ceded insurance.

In their analysis of ELIC's annual financial statements for 1980 and 1982, department examiners detected reinsurance agreements between ELIC and nonadmitted companies where either no funds were withheld or the letters of credit were not acceptable to the department. If these nonadmitted insurers either could not or would not pay for the losses associated with the business that ELIC reinsured with them, then ELIC would be responsible for paying for the losses on such business. An insurer faced with this situation can use funds or letters of credit obtained from its nonadmitted reinsurers to pay these losses. However, ELIC neither withheld funds nor obtained acceptable letters of credit in amounts sufficient to pay for the estimated losses related to the business it ceded to these nonadmitted reinsurers.

Furthermore, department examiners noted ELIC had reinsured a significant amount of its business with affiliates. In addition, the ratio analysis the NAIC performed on ELIC's 1980 financial statement recommended immediate regulatory attention be given to reinsurance transactions between ELIC and its affiliates. By reinsuring business with its affiliates, an insurer only spreads its risk to other members of its affiliated group. In the event of large or catastrophic losses, this strategy could cause the whole affiliated group to become insolvent. Finally, according to the department's analysis of the 1983 annual financial statement ELIC filed, of a $406 million reduction made to its loss reserves reflecting business ELIC ceded to reinsurers (reinsurance credit), more than 50 percent represented business reinsured with nonadmitted companies that may or may not have been able to meet these substantial obligations to ELIC. (An insurer uses reinsurance credits in reducing its estimated liability for losses associated with reinsured business.)

In May 1985, the department issued its report of examination of ELIC covering the three-year period ended December 31, 1983. The examiners determined ELIC had claimed reinsurance credits of $188 million on its 1983 annual statement for reinsurance arrangements where there was no transfer of liability from ELIC to the reinsurers. Section 922.3 of the California Insurance Code prohibits an insurer from claiming any reinsurance credit unless the reinsurer agrees to indemnify the ceding insurer, not only in form but in fact, against all or part of the loss or liability arising out of the original insurance. Despite the finding, the department did not disallow the reinsurance credits ELIC claimed where no transfer of risk occurred; rather, the department allowed ELIC to reduce the amount of reinsurance credits it was claiming to zero over a three-year period. As a result of the examination, the department determined that ELIC's capital and surplus was $110 million. However, had the department refused to accept the $188 million in reinsurance credits ELIC claimed as of the examination date, the company would have appeared to have been insolvent by $78 million as of December 31, 1983.

Between 1985 and early 1987, the department continued to have questions about ELIC's reinsurance activities. In early 1987, examiners for the New York Insurance Department found that Executive Life of New York (ELNY), a subsidiary of ELIC, had transacted reinsurance arrangements that failed to meet the requirements imposed by the New York Insurance Department and by New York insurance laws. As a result, the New York department required ELNY to increase its capital and surplus by approximately $152 million, fined it $250,000, and required three ELNY officers to resign. After New York's findings, the chief of the financial analysis division for California's Department of Insurance recommended in March 1987 that the department start an examination of ELIC as soon as possible since ELIC was reinsured at that time with some of the same reinsurers ELNY had used that were in violation of New York's insurance laws.

After a review of ELIC's 1986 annual statement, the department's examiner noted that the reinsurance arrangements the department had taken issue with and ordered phased out after

the 1983 examination had proliferated instead of abated. Reinsurance credits ELIC claimed as of December 31, 1986, amounted to $1.06 billion, 96 percent of which represented reinsurance with either nonadmitted or affiliated reinsurers. In March 1987, the chief of the financial analysis division and two examiners from the department met with officers and actuarial consultants of ELIC to discuss the department's concerns regarding several of ELIC's reinsurance agreements and to seek additional information. In that meeting, the chief advised ELIC of the department's view that the company had failed to fulfill its commitment to phase out the problem reinsurance and not enter into any new agreements having the same features. Further, in summarizing the results of that meeting to the former insurance commissioner, the chief noted that ELIC had claimed questionable reinsurance credits totaling $766 million as of December 31, 1986, when ELIC reported a surplus of only $270 million.

Discussions between the department and ELIC regarding the company's improper reinsurance agreements and letters of credit continued throughout the rest of 1987, culminating with the department disallowing a $180 million reinsurance credit claimed as of December 31, 1986. As a result of this disallowance, the former commissioner instructed ELIC to amend the filing of its 1986 financial statement to reflect the disallowance of reinsurance credit. In addition, the former commissioner warned ELIC that the department would not condone its continuing disregard of statutes and regulations. The commissioner also warned the company that the department expected ELIC's cooperation in resolving all material issues relative to its financial condition before December 31, 1987. Subsequently, in April 1988, the department issued its report of examination of ELIC covering the four years ended December 31, 1987. The report identified various letters of credit and reinsurance contracts that did not comply with either the department's requirements or the California Insurance Code. The report stated that ELIC was in the process of requesting that the appropriate reinsurers and banks make the revisions necessary to correct the unacceptable letters of credit to comply with the department's requirements by December 31, 1988. Further, ELIC promised the department it would amend the unacceptable reinsurance contracts to comply with the law.

In April 1989, the NAIC, in its review summary of ELIC's 1988 annual statement, noted that the company had taken more than $888 million in reinsurance credits for business reinsured by affiliated companies in 1988. This amount represented 72 percent of the total reinsurance credits ELIC claimed. The NAIC recommended that ELIC receive regulatory attention, in part, because of its reinsurance activities.

In March 1991, the department's review of ELIC's 1990 annual statement indicated ELIC's reinsurance arrangements and reinsurance credits claimed for ceded reinsurance remained a major concern. The department's analyst indicated the department needed to do more detailed analytical work on ELIC's reinsurance activities. On May 10, 1991, the department finished a report of examination of ELIC declaring the company was operating in a hazardous manner. ELIC was placed in a court-supervised conservation because it had a negative surplus of approximately $356 million as of December 31, 1990. A negative surplus of this magnitude indicated ELIC was insolvent. The department would not accept as valid a total of approximately $147 million in improper reinsurance credit ELIC claimed as a result of the examination. The department disallowed the reinsurance credits because either the reinsurers had no legally binding obligation to reimburse ELIC for the benefits it was obligated to pay its policyholders or because the reinsurers' obligations to ELIC were no greater than the amounts ELIC would be required to pay. Furthermore, the department also found ELIC had failed to report a liability of approximately $81 million in recognition of the net amount owed to affiliates for reinsurance it assumed from them. Reinsurance assumed is that portion of risk the reinsurer accepts from others, in this case ELIC's affiliates.

According to the department's legal counsel, it has been the department's long-standing policy to defer disallowance of reinsurance credits under circumstances where there would be an immediate and drastic impact upon surplus were such credits disallowed immediately. Historically, the department has seen fit and prefers to insist upon a gradual reduction of the reserve credits over time so as to spread out the impact on surplus. However,

because the type of reinsurance the department had originally ordered ELIC to phase out after the 1983 examination had instead simply been replaced by other reinsurance having the same features, the department's policy did not have the desired result. According to the chief of the financial analysis division, effective April 1991, the department began requiring insurers to reduce most, if not all, reinsurance credits arising from reinsurance arrangements that do not comply with the California Insurance Code.

The department first noted potential problems with ELIC's reinsurance in 1980. However, in subsequent years, the department did not ensure that ELIC corrected the deficiencies detected in its improper reinsurance arrangements and did not monitor ELIC closely enough to prevent it from entering into other reinsurance arrangements having the same objectionable features. More than ten years later, in 1991, the department found ELIC insolvent due, in part, to approximately $228 million in improper reinsurance.

Improper Affiliate Transactions

During the late 1970s and early 1980s, both the department and the NAIC identified ELIC's investments in affiliates as an area requiring regulatory attention. In 1987, the NAIC again recommended immediate regulatory attention be given ELIC because of large surplus contributions made by its parent company, First Executive Corporation, during 1986 and because of ELIC's transactions with its affiliates. Further, the department was also aware that, had First Executive Corporation not made two contributions totaling $300 million to ELIC's surplus during 1986, ELIC would have been insolvent as of December 31, 1986. In addition, both the department's and NAIC's analysis of ELIC's 1986 annual statement indicated that credit claimed for reinsurance had increased by approximately $317 million over the previous year to a total of $1.059 billion. Of the $1.059 billion in reinsurance credit ELIC claimed, the department noted that $609 million related to reinsurance placed with affiliates not authorized to transact insurance business in California.

In March 1987, the department discussed with ELIC the fact that its $131 million contribution to ELNY in February 1987 required approval of the insurance commissioner under California insurance laws and that ELIC did not seek such approval. However, ELIC maintained that the transaction was exempt from California insurance laws. Further, in April 1987, the department again informed ELIC that it neither reported to the department nor requested the former commissioner's approval for several affiliate transactions occurring during 1986 and 1987 and totaling $460 million even though these transactions were reportable under California's Holding Company Act. ELIC responded to the department by contending that some of the transactions were not covered by California insurance laws and one was entered into with the full knowledge and consent of the department. We could find no evidence that these differences in opinion between the department and ELIC regarding ELIC's failure to seek prior approvals were ever resolved one way or the other. However, in July 1987, ELIC's counsel disclosed in a letter to the department that the $131 million contribution ELIC made to ELNY was in partial payment of a stipulation entered into between ELNY and New York's Insurance Department requiring that a $151.5 million cash infusion be made to ELNY's surplus. The cash infusion was necessary to replace reinsurance credit ELNY claimed in violation of the New York insurance laws. ELIC's counsel admitted that the contribution made to ELNY required the former commissioner's prior approval but, because of the circumstances, requested that the transaction be exempted. Apparently, such an exemption was granted since the department did not take any action regarding ELIC's violation of the California Holding Company Act.

In February 1988, ELIC applied to the department for a permit to issue a contribution certificate for $170 million to First Executive Corporation in return for two promissory or demand notes. A contribution certificate, sometimes called a surplus note, is a special type of promissory note containing severe restrictions regarding repayment that allows the issuing company to treat the certificate as a part of its surplus rather than as a liability. Demand notes are notes payable by the issuing company as of a specified date and shown by the receiving company as a receivable due from

the issuing company until the demand date of the note. Although the certificate was executed in March 1988, ELIC dated the certificate to be effective on December 31, 1987, and claimed the $170 million as part of its surplus on its 1987 annual statement. However, ELIC did not receive any cash until at least March 1988. Before approving the issuance of the certificate, the chief of the department's financial analysis division had concerns about the precedent the department would set by allowing surplus to be built by essentially a paper transaction. However, according to the chief, the demand notes, together with $175 million in cash already contributed by First Executive Corporation on December 31, 1987, were replacing surplus that was the product of questionable reinsurance arrangements. Therefore, according to the chief, ELIC was in no worse a position with the demand notes than it had been with the questionable reinsurance.

In April 1988, the department issued its report of examination of ELIC for the four years ended December 31, 1987. The department's examiners found ELIC was a party to seven affiliate transactions completed between June 1984 and December 1986 that violated California's Holding Company Act. All seven transactions required the commissioner's prior approval, which was not obtained. The seven affiliate transactions totaled $500 million. In April 1988, ELIC retroactively sought the former commissioner's approval concerning four of the seven transactions. The department's examiners also found ELIC had misclassified its $131 million contribution to ELNY as "other invested assets." The department recommended that ELIC reclassify its contribution as "investments in subsidiaries (common stock)." The examiners held that, because ELNY could not repay ELIC the principal and interest relating to the $131 million contribution without first obtaining the approval of New York's Insurance Department, the reclassification was necessary to more clearly describe the nature of the transaction.

As a result of the examination, the department determined that ELIC's surplus was $135 million as of December 31, 1987, a reduction of $69 million from the $204 million in surplus originally reported by ELIC. However, had the department

disallowed a further $170 million surplus contribution in the form of the two demand notes backdated to be effective December 31, 1987, ELIC would have appeared to have been insolvent by $35 million as of that date.

Another indication that affiliate transactions needed regulatory scrutiny was included in the NAIC's review of ELIC's 1988 annual statements completed in April 1989. In its review, the NAIC noted that ELIC had claimed reinsurance credits in excess of $888 million from affiliated companies, comprising up to 72 percent of the total reinsurance credits claimed that year.

Furthermore, in November 1989, the department directed ELIC to immediately file an application for prior approval for the purchase of collateralized bond obligations (CBO) amounting to $771 million that were purchased in December 1988 from six affiliated partnerships. CBOs are debt securities secured by a pool of non-investment grade bonds, known as junk bonds. ELIC purchased the CBOs by transferring its junk bonds to the six affiliated partnerships, in each of which ELIC was a 99 percent partner. With the CBO transaction, ELIC was able to reduce its mandatory securities valuation reserve (MSVR) by approximately $110 million. An MSVR is a reserve set up by an insurer to protect against reductions to its surplus due to losses from bond and equity securities investments. Any realized and unrealized losses in its investment portfolio are charged against the MSVR. A realized loss is the difference between the net proceeds from the sale of a marketable security and its cost. An unrealized loss is the difference between the current market value and the purchase price of a marketable security without regard to its sales price. In December 1989, the department determined that ELIC's investments in CBOs were not authorized by the California Insurance Code. The department also directed ELIC to recalculate its MSVR as of December 31, 1988, to reflect the underlying junk bonds used as collateral in securing the December 1988 CBO transaction. Further, it instructed the company to fully disclose the substance of the transaction in its 1989 annual statement. Finally, in February 1990, ELIC stated that the CBOs would be rescinded, and it would retrieve all the junk bonds transferred to the CBO issuers. ELIC would also restore the approximately $110 million related to the CBO transaction to its MSVR.

In March 1990, ELIC agreed to give the former insurance commissioner 30 days prior written notice with regards to certain types of affiliate transactions. Further, in September 1990, the department scheduled an examination of ELIC to begin in October 1990 covering the three years ended December 31, 1990. In December 1990, the department ordered ELIC to request prior written approval from the department to transfer any cash or other assets in excess of $100,000 from ELIC to any of its affiliates.

In March 1991, the department's review of ELIC's 1990 annual statement indicated that the investments in affiliates shown in ELIC's "other assets" account more than doubled from $314 million to $639 million and that total investments in affiliates had grown to $777 million, well in excess of ELIC's capital and surplus. The department's examiner noted that some of the investments in affiliates were not first submitted to the department for prior approval as required by law. Furthermore, the examiner believed that many of the recorded values assigned to the assets in this account were far in excess of their true worth. For example, the examiner cited the fact that ELIC had reported more than $139 million as additional investments in an affiliate in 1990 that, only the year before, ELIC had shown as having a statement value of $1.

On April 8, 1991, the chief of the department's financial analysis division confirmed in writing to the insurance commissioner that First Executive Corporation's independent accountants did not express an opinion on the financial statements of First Executive because of their substantial doubt about the parent company's ability to continue. Subsequently, on April 10, 1991, ELIC's president informed the insurance commissioner that ELIC might have been impaired at March 31, 1991, because of a series of bond defaults and adjustments required by regulatory authorities. Finally, on April 11, 1991, the California insurance commissioner found ELIC to be operating in a hazardous manner and placed it under conservatorship.

On May 10, 1991, the department finished its report of examination that declared ELIC insolvent by $356 million as of December 31, 1990. The department found that, between 1989 and 1990, ELIC entered into various improper transactions with affiliates totaling approximately $485 million. These transactions were either in violation of the California Insurance Code or the department's regulations or directives. The department also found that ELIC had not reclassified its $131 million contribution to ELNY as "investments in subsidiaries (common stock)" as the department recommended in 1988. The department again recommended the transaction be reclassified in the annual statement. In addition, the department found ELIC had overvalued its investments in the common stocks of its affiliates by approximately $45 million and had overvalued its investments in joint ventures and limited partnerships by another $87 million. Finally, the department's examination found that, because the $131 million ELIC had contributed to ELNY was in reality an investment in the common stock of an affiliate and those stocks had declined in value by more than ELIC's entire investment, the investment had virtually no value.

The department first detected problems with ELIC's affiliate transactions in 1980. In subsequent years, the department did not take any regulatory actions against ELIC even when the company repeatedly violated the California Holding Company Act through its dealings with affiliates. Eleven years later, in 1991, the department found ELIC to be insolvent, in part, because of its improper affiliate transactions. Department examiners found ELIC had made $485 million in affiliate transactions during 1989 and 1990 alone that were improper because they either violated the law or the department's regulations or directives.

Reserve Deficiencies

The department first noted concerns regarding potential problems with ELIC's reserves in April 1978. At that time, a department examiner, who had received the NAIC's synopsis of review of ELIC's 1977 annual statement, raised questions concerning the

dramatic growth in group annuity business. Among other concerns, the examiner questioned whether ELIC had calculated its reserves for individual annuities according to the method required for business written in California. In June 1978, the examiner wrote to ELIC's treasurer posing that question, among others. In September 1978, ELIC's treasurer responded, stating that ELIC would calculate its reserves using the California method in its 1978 annual statement.

Between 1981 and 1984, the department received ratio reports from the NAIC of key financial ratios computed from ELIC's annual statements for the years 1980 through 1983. For all four years, the NAIC noted that the ratio that measures the change in ELIC's reserves was considered unusual compared with the ratios of other life insurers in the industry.

In June 1984, the department's chief actuary wrote to the commissioner of the Michigan Insurance Bureau in response to an inquiry about the adequacy of ELIC's reserves. The department's actuary stated that the department had initially withheld its certification of the adequacy of ELIC's annual reserves for 1982 pending clarification of issues regarding reinsurance involving more than $45 million in reserves placed with reinsurers located outside the United States. The actuary advised Michigan's commissioner that ELIC had ample surplus to cover the reserve amount being questioned.

In May 1985, the department completed its examination of ELIC covering the three years ended December 31, 1983. Based on their examination, the examiners required ELIC to increase its reserves for life policies and contracts by more than $79 million, reducing capital and surplus by the same amount. The reason examiners gave for the requirement to increase reserves was that ELIC had not reserved for the amount representing the difference between the interest guaranteed policyholders on single premium deferred annuities and the amount ELIC had already reserved using statutory valuation rates. The Standard Valuation Law contained in the California Insurance Code requires that a life insurer include in its statutory reserves an amount sufficient to cover the present value of all future benefits guaranteed to the policyholders of the insurer.

In September 1985, the chief actuary and other department representatives met with two of ELIC's vice presidents. The purpose of the meeting was to discuss a proposed reinsurance agreement and the fact that, since the last field examination, ELIC had been writing a large volume of single premium whole life policies without the department first reviewing the insurance plan, as required by law. ELIC's officers agreed, among other things, to demonstrate to the department that the company's single premium whole life plan complied with the minimum standards contained in the insurance code with respect to reserves and nonforfeiture values and all other requirements involved in the filing of a policy plan with the department. ELIC was to complete the demonstration within 15 days. However, we found no evidence in the department's files that ELIC had complied with the agreement.

In February 1987, one of the department's actuaries recorded the decisions reached in a conference held between actuarial staff and an examiner from the financial analysis division. At the conference, it was unanimously recommended that the valuation certificate regarding the adequacy of ELIC's reserves as of December 31, 1985, be withheld until outstanding reinsurance questions had been resolved. The conference attendees also recommended that priority be given to conducting the regular triennial field examination of ELIC as of December 31, 1986.

In a 1988 note written to the chief of the financial analysis division, a department analyst described two reasons for the continuing strain on ELIC's surplus. One was referred to as a "business generated surplus strain" and the other as an "investment generated surplus strain." The analyst explained the business generated surplus strain as occurring because of ELIC's choice in marketing primarily annuities with single premiums and long-term interest guarantees that exceeded the interest rates the insurance code prescribed. The effect of this strategy on ELIC's surplus was that the premiums received needed to be set aside intact to cover ELIC's immediate administrative costs and marketing expenses associated with selling this type of product. In addition, ELIC needed to establish a reserve representing the difference between the interest rate it guaranteed its annuity policyholders over the time guaranteed and the maximum interest rate prescribed by law.

According to the department analyst, to reduce the reserves relating to its issuance costs and excess interest guarantees and, thus, increase its surplus, ELIC entered into "surplus relief reinsurance" treaties with several reinsurers, some of whom were located outside the United States. Most of these reinsurers were not licensed in California or in the other states where ELIC does business. The department concluded in its 1983 examination of ELIC that reinsurance agreements amounting to more than $188 million did not transfer any liability to the ceding insurer, and, therefore, were not acceptable according to California guidelines, which require that the ceding insurer transfer liability. However, rather than requiring ELIC to increase its reserves by $188 million, the department chose to allow ELIC to phase out the surplus relief reinsurance agreements over three years.

The analyst, in the 1988 note to the chief of the financial analysis division, also described the nature of the products ELIC markets, namely annuities, as the cause for ELIC's investment generated surplus strain. To pay the higher interest rates ELIC guaranteed to policyholders purchasing its annuities, ELIC had to invest in high-yield non-investment grade bonds. As a result of marketing these products, ELIC had to maintain a reserve to anticipate losses from bond and securities investments. The NAIC's statutory accounting requirements dictate that life insurers investing in bonds or preferred or common stocks establish a reserve called the MSVR to anticipate the losses associated with investing in these riskier types of securities. The amount of the MSVR required is dependent on how risky the security is according to the designation the NAIC's Securities Valuation Office assigns. The lower the investment grade, the higher the reserve amount required. Because ELIC invested in higher-risk securities, it had to maintain a larger MSVR, placing a strain on its financial condition.

In April 1988, the department completed its examination of ELIC for the four years ended December 31, 1987. The examiners required that ELIC increase its reserves by $49 million. The majority of the increase was required because ELIC had used a valuation method in calculating its reserves that was not in conformity with department regulations.

In March 1990, the department received the NAIC's report of key financial ratios computed from ELIC's 1989 annual statement. Although the report showed only one ratio as falling outside the normal range, it noted that the company's MSVR had fallen by more than $166 million since the previous year, mainly because of losses ELIC suffered on the sale of its bonds.

In an August 1990 memorandum summarizing his review of ELIC's financial condition as of June 1990, a department analyst noted that ELIC's MSVR had declined $271 million during the six months since December 1989 and now stood at $312 million. The analyst believed that, as a cushion for the decline in the market value of securities, the MSVR provided little protection. As of June 1990, the MSVR represented 3.9 percent of ELIC's securities portfolio. The analyst considered this a bad sign in light of the commonly held opinion at that time that the stock market was expecting a recession that would further reduce the market value of ELIC's huge holdings of junk bonds.

According to the department's March 1991 review of ELIC's 1990 annual statement, the MSVR had shrunk to just $54 million, reducing the bond and preferred stock component of the reserve to zero. In summarizing the results of his review, the department examiner concluded that by no longer maintaining an MSVR for bonds, ELIC would not have a reserve available to offset losses associated with the sales of bonds during 1991. Further, any realized or unrealized losses on bonds would cause a direct reduction to ELIC's surplus. Finally, the department examiner noted that ELIC had changed its valuation method in calculating the reserve for whole life policies. This change resulted in an $86 million reduction in ELIC's reserves for these policies while ELIC's obligations remained the same. The examiner concluded that ELIC's new valuation method meant whole life policyholders were less protected.

At the end of March 1991, the department's chief actuary reported to the commissioner concerning one of the preliminary findings of the then ongoing examination of ELIC. The actuary stated that, after reviewing all of ELIC's surplus relief reinsurance

arrangements, 15 such arrangements were identified as not transferring any risk to the reinsurer. ELIC's basic liability for paying annuity benefits remained unchanged even though the business had been reinsured. The examiners required that ELIC increase its reserves for life policies and contracts by a total of approximately $144 million in recognition of ELIC's potential liability for such reinsured business.

On May 10, 1991, the department finished its examination of ELIC for the three years ended December 31, 1990. The examiners required ELIC to increase its reserves for life policies and contracts by more than $232 million. The increase to reserves included the preliminary increase of $144 million required in March 1991, an additional surplus relief reinsurance arrangement examiners later identified as failing to transfer risk amounting to approximately $3 million, and an additional $85 million reflecting the department's decision not to accept the valuation method ELIC used in establishing its whole life policy reserves.

Although the department had had ongoing concerns about ELIC's reserves since 1978, other than requiring ELIC to increase its reserves as a result of the 1983, 1987 and 1990 examinations, the department failed to act on the problem causing these reserve shortages, namely ELIC's huge increase in the sale of interest guaranteed annuity products.

First California Property and Casualty Insurance Company

First California Property and Casualty Insurance Company

State of Domicile: California
Net premium written in 1988: $7.2 million
Status: liquidated October 1989

Hazardous Conditions Exhibited		Year First Noted
Questionable investments	☑	1989
Improper reinsurance	☐	
Improper affiliate transactions	☑	1987
Reserve deficiencies	☑	1987
Poor underwriting	☐	
Poor use of managing general agents	☐	
Agents' high balances	☐	

The factors that eventually led to the failure of the First California Property and Casualty Company (First California) included questionable investments, improper affiliate transactions, and reserve deficiencies. While the California Department of Insurance (department) was able to detect the hazardous conditions relating to improper affiliate transactions and reserve deficiencies well before First California's failure, it did not take formal actions to ensure the company took prompt and effective action to correct them. Following is a detailed presentation of those factors leading to First California's failure.

Questionable Investments

In June 1983, a department examiner wrote a memorandum about his review of First California's 1982 annual and March 31, 1983, quarterly statements. The examiner was concerned that, as of

March 31, 1983, the insurer's surplus had decreased by more than $213,000 to approximately $2 million in the insurer's first year of operation. In the memorandum, the examiner stated he had telephoned First California's president to find out what plans the insurer had to increase the amount of business it was writing. Among the other subjects discussed, the examiner asked First California's president about $300,000 in deposits, representing 15 percent of surplus, placed with one particular bank as of March 31, 1983. According to the examiner, the president explained that First California's controlling stockholder was also the chairman of the board for the bank where the funds were deposited. The president stated that he was in the process of moving some of the funds to better diversify First California's investment portfolio. Based on the president's plans to move some of the funds, the examiner believed it was premature to schedule an examination of the insurer at that time.

During September and October 1984, First California's president and the department corresponded concerning an investment the president wanted to make. The company's president wanted the department's opinion because the investment was of a type the insurance code did not seem to address. The investment was described as a repurchase agreement with a federally chartered bank, whereby First California would purchase a percentage of the guaranteed portions of small business administration loans that the bank previously purchased. First California's president believed that if he could take advantage of this type of investment program, First California would gain a sizable return on its investment. The bank that First California proposed entering into the repurchase agreement with was the same bank whose chairman had a controlling interest in the insurer.

The department requested more information about the proposed investment program, such as a prospectus or similar kind of document. The president replied that, because this was a private agreement between the bank and First California, no prospectus or similar document was available. However, the president did provide the department with a copy of the certificate of participation form the bank used in investment transactions of this

type. After reviewing the information furnished, the department informed First California's president that the investment did not qualify under code sections related to general investments, but would qualify under a code section called the leeway law. This section of the Insurance Code, Section 1210, states that after an incorporated insurer has invested an amount equal to its minimum paid-in capital in the types of securities allowed by the general investment code sections, it may make discretionary investments within specified limits. We were unable to determine from the department's files whether or not First California made such a discretionary investment.

In April 1987, the department received a report from the NAIC of key financial ratios computed from First California's 1986 annual statement. The report found First California had six ratios that were unusual when compared with industry averages. One of the unusual ratios was for investment yield. The result of this ratio provides an indication of the general quality of the insurer's investment portfolio. In First California's case, the ratio indicated that it might be heavily invested in low-yield securities.

The department completed an examination of First California in August 1987 covering the three years ended December 31, 1986. Although the examiners did not comment on First California's investments, they noted that, included in the $1,000,853 policyholders' surplus, was $1 million First California's parent company contributed in December 1986. In other words, without the contribution to surplus, First California would have had a surplus of only $853 with which to cover policyholders' claims. Furthermore, the examiners noted that, to make the surplus contribution, the parent company had obtained a bank loan personally secured by each member of the parent company's board of directors.

In September 1987, a supervising examiner of the department wrote to First California's president informing him that, based on the department's examination, First California was in hazardous financial condition. The examiner requested a meeting with the president to discuss the company's future operations.

Although we could find no record of what was decided at this September meeting, we did find a department memorandum, dated the same day as the scheduled meeting, which discussed the company's need to obtain an infusion of funds. Furthermore, on December 1, 1987, the department received an application from a potential buyer for the purchase of a controlling share of First California, indicating that approval was conditioned on a $1.5 million cash infusion.

In February 1988, the department conditionally approved the application to purchase a controlling interest in First California. The department's first condition was that the new buyer could not pledge the stock of First California, its parent company, or any of its affiliates in securing the $1.5 million note borrowed to provide the cash infusion. The second condition stipulated that the $1.5 million cash infusion must be placed in escrow and infused into First California within 24 hours of the acquisition of the company.

The new buyer of First California also served as the chief executive officer (CEO) of another insurance company located in the state of Colorado. In a March 1988 letter to the chief of the financial analysis division, the new buyer of First California asked for the department's approval in allowing First California to purchase the Colorado insurer for $2.2 million. The chief of the financial analysis division responded that month by refusing to allow First California to purchase the Colorado insurer. However, he stated the department would consider the new buyer's request to contribute the Colorado insurance company to First California at the statutory value of the Colorado company's policyholders' surplus. The chief of the financial analysis division added that, if the department granted such a request, First California would not be allowed to use the surplus of the Colorado insurance company to enable it to write additional business in California. In June 1988, the department granted approval for the contribution of the statutory value of the Colorado insurance company to First California, provided that the surplus of the Colorado company would not be used to write additional premiums in California.

In November 1988, First California's new CEO informed the department that the planned contribution of the Colorado-based insurance company to First California would not take place because the department of insurance in Colorado had not approved the transaction. In addition, the CEO stated that, because one of the Colorado insurer's subsidiaries was in receivership, First California was abandoning the transaction and would not complete it in the future. Receivership is a court-ordered condition naming an individual as a receiver with authority to hold the property and administer the operations of an insurer pending further litigation.

In May 1989, one of the department's examiners wrote to First California's CEO summarizing the comments and requests from a meeting held between department representatives and First California. Many of the department's requests were for documents supporting various investments shown on First California's 1988 annual statement. For example, the department requested appraisal reports and deeds of trust supporting the value of five real-estate investments totaling approximately $2.4 million. In addition, the department requested that First California submit documentation to the NAIC supporting the value of a long-term investment in a company in Texas. First California reported the investment as worth $1.5 million. Finally, the department questioned First California regarding its holdings in the preferred stock of one company and the common stock of another totaling a reported market value of just under $685,000. The department requested the financial statements for both these companies in addition to requesting that First California have the NAIC value the investment in preferred stock. Also, the department requested the latest quoted trading price for First California's investment in the shares of common stock. First California was to provide the department with all the requested documents by May 17, 1989. However, we found no evidence in the department's files to suggest that First California ever complied with the department's request.

The department scheduled a limited examination of First California in July 1989 covering the two and one half years ended June 30, 1989. At the end of July 1989, one of the department's examiners sent the department an interim report showing the

insurer's financial condition as of March 1989. The examiner stated he had identified more than $6 million worth of assets that First California had originally included in its March 1989 quarterly statement that it had since written off or charged to losses as of June 30, 1989. According to a schedule the examiner provided, if the insurer was not able to replace the assets written off or charged to losses, First California was insolvent by $1.3 million as of March 31, 1989.

The department completed the limited examination of First California in August 1989. The department's examiners limited their original review to an analysis and evaluation of the insurer's assets and found First California to be insolvent by $3.1 million at June 30, 1989. First California was placed into conservation on September 6, 1989. The department subsequently expanded the scope of its earlier examination to include an examination of loss reserves, loss adjustment expense reserves, and agents' balances. Based on the results of this expanded examination, the department revised the amount of the insolvency to almost $7 million at June 30, 1989. The department's examiners found First California held questionable and overvalued investments totaling more than $9.5 million.

As early as June 1983, the department registered concerns regarding First California's investment practices. However, it appears the majority of First California's questionable investments occurred during 1988 and early 1989. The department detected the questionable investments through its analysis of First California's 1988 annual statement and discussed them in a letter to the company's CEO during May 1989. In its field examination of First California completed in August 1989, the department rejected the majority of these investments. First California was conserved in September 1989. It is doubtful the department could have detected First California's questionable investments any earlier than it did because information in quarterly financial statements concerning an insurer's investments is too limited to answer questions of valuation and ownership.

Improper Affiliate Transactions

The department found problems with First California's affiliate transactions during an examination covering the three years ended December 31, 1986. The department's examination, completed in August 1987, noted First California was involved in a monthly expense allocation plan with its parent company and an affiliate. Under the plan, First California would pay for expenses incurred by its parent and affiliate and would be reimbursed at a later time. However, First California had never executed a written agreement between itself and its parent or affiliate defining the payment schedule for such intercompany balances. Furthermore, the examiners reviewed the ability of the parent and affiliate to repay the amount owed to First California as of December 31, 1986. The examiners determined that neither the parent company nor the affiliate had sufficient liquid assets to repay First California as of December 31, 1986. Consequently, the examiners reduced the receivable shown by First California from $896,000 to $350,000.

The department made no further reference to concerns regarding First California's affiliate transactions until May 1989. At that time, in a letter to First California's CEO, a department examiner summarized the results of a meeting held earlier that month between department representatives and First California. One of the items discussed and included in the letter concerned a $1.8 million receivable due from First California's parent. This receivable represented expenses the insurer paid on behalf of its parent. The examiner noted in his letter that First California's CEO, who was also the controlling stockholder of the parent company, had provided a $1.5 million letter of credit guaranteeing the receivable. However, the examiner stated that the letter of credit was unacceptable to the department as a means of securing the receivable. Furthermore, the examiner stated that the former commissioner should have approved the transaction providing the letter of credit before its completion. The department requested that, by May 17, 1989, First California's CEO provide documentation that all amounts the parent company borrowed had been returned to the insurer in a form acceptable to the department.

In addition, the department requested that First California provide a schedule showing the composition of $2.5 million due from its agents as of December 31, 1988, and the subsequent payments or credits related to payment of the receivable. The department wanted to use the schedule as a means of determining if and when these balances were remitted to First California. The examiner noted that an affiliate owed approximately two thirds of the $2.5 million to First California while the company's independent agents owed the balance. Further, the department requested First California's CEO provide financial statements supporting First California's $220,000 investment in the common stock of another affiliate. Finally, the examiner noted that, during 1988, First California had invested an additional $600,000 in the stock of yet another affiliate only to write the entire investment off in the same year. The examiner closed by stating that the department anticipated that First California's CEO would be able to secure additional funds to bring its surplus up to approximately $4 million.

In July 1989, the field examination division acknowledged a request from the financial analysis division for an examination of First California. The examination was scheduled to begin that same month and cover the period ended June 30, 1989, focusing on the insurer's solvency and affiliated transactions, among other areas of concern.

At the end of July 1989, the examiner for this examination provided an interim report to his supervisor. The examiner stated that he had already identified more than $6 million worth of assets First California reported in its March 1989 quarterly financial statement that, by June 1989, the insurer had written off or charged to losses. Of this $6 million in assets, approximately $2 million represented amounts due from affiliates. The examiner indicated in a schedule he had prepared that if the insurer were unable to replace these assets, it was insolvent by $1.3 million as of June 30, 1989.

In August 1989, the department's examiners completed a limited examination of First California. The scope of this examination was limited to the analysis and evaluation of certain assets the insurer held as of June 30, 1989. It was the examiners'

opinion First California was insolvent by more than $3.1 million at that time. The examination report noted that employees of First California performed services for both its parent and one of its affiliates. The examiners stated that First California appeared to receive little, if any, compensation for the services its employees rendered. In fact, the examiners stated First California had written off almost $2.4 million due from its parent and the affiliate in June 1989 relating to the services it rendered. At the time of the examination, there was no management agreement in effect covering the provision of, or payment for, such intercompany services. It is interesting to note that this is similar to the finding the department's examiners cited in their previous examination of First California as of December 31, 1986. In that examination, the examiners concluded the company had received little or no compensation from its parent and affiliate under an agreement regarding the monthly allocation of general expenses between First California and its affiliates.

On September 6, 1989, the former commissioner was appointed conservator of First California after the limited examination of the insurer was expanded and the size of its insolvency was found to be much larger than was originally identified by the limited examination. In a memorandum announcing the conservatorship of First California, the department stated that efforts were underway to rehabilitate the insurer. However, in a memorandum written to the chief of the department's conservation and liquidation division in late September, the chief of the financial analysis division expressed concern that the competence, character, and integrity of First California's CEO was very questionable. According to the memorandum, it was the chief of the financial analysis division's understanding that First California was going to receive a $6.5 million infusion to surplus through a line of credit and a loan. The chief believed the department would be remiss if it did not investigate certain transactions before returning control of First California to its CEO. The issues the chief wanted investigated included the write-off in June 1989 of the amount due First California from its parent and affiliate and the removal of $335,000 from the insurer the day after the insurer was notified of the department's application for conservatorship.

During its examination of First California completed in August 1987, the department noted that no executed service agreement existed between the insurer, its parent company, and an affiliate defining the types of services rendered or the scheduled repayments to be made to the insurer for such rendered services. Apparently, the department never followed up on this issue by requesting a copy of such an executed agreement. Subsequently, in its examination of First California completed in August 1989, examiners noted the insurer had written off a $2.4 million receivable representing amounts due from its parent and the affiliate for services rendered. Had the department followed up on this issue initially by requiring an executed agreement and monitoring subsequent performance under that agreement, it is possible that the magnitude of the uncollectible amount due from First California's parent company and the affiliate could have been reduced.

Reserve Deficiencies

Although the department was aware of First California's problem with its reserves for more than two years, it did not take all available regulatory measures to ensure that First California corrected its reserve deficiencies. Loss reserves are funds insurers hold to pay for present and future losses from policyholders' claims. Loss adjustment expense reserves are funds insurers hold to cover the costs associated with adjusting and settling claims and losses. The amount an insurer holds in its reserves should be based on the insurer's experience or, where experience is lacking, on reasonable actuarial analyses of the losses expected for the types of coverage the insurer writes.

In August 1987, the department completed its field examination of First California as of December 31, 1986. The examination revealed the company had a $1.4 million deficiency in its loss and loss adjustment expense reserves. Furthermore, First California's adjusted policyholders' surplus was $1,000,853. This surplus amount included a $1 million cash contribution First California's parent company made in 1986. Without the cash

infusion, First California, as of December 31, 1986, would not have had the $1 million in surplus required by California law to be deemed statutorily solvent. Although we found the department requested a meeting with First California officials in September 1987 to discuss the company's financial condition, we could not find any evidence that the meeting took place. However, according to the chief of financial surveillance, who was at that time chief of the financial analysis division, the meeting did take place during the fourth quarter of 1987. According to the chief, the meeting was attended by himself, a former chief deputy commissioner, and First California's president. The items discussed included First California's financial problems and the company's need for a capital infusion as well as problems relating to one of the company's managing general agents.

In February 1988, the department approved the acquisition of First California by the president of two other insurance companies located in Oklahoma and Colorado. The purchaser agreed to infuse $1.5 million into First California, an amount necessary to ensure the immediate survival of the company. In March 1988, the NAIC's analysis of key financial ratios confirmed First California was seriously underreserved for its losses as of December 31, 1987, and recommended that the department accord the company immediate regulatory attention. In the same month, the department completed a market conduct examination covering 1987 that also found First California was underreserved in both its personal and commercial lines. The purpose of a market conduct examination is to evaluate an insurer's compliance with requirements in the California Insurance Code regarding selling, advertising, underwriting, rating, and claims servicing.

Although the department and First California's new CEO corresponded regularly during 1988 concerning ways to infuse additional capital into First California, in June 1988, the department still placed First California on its internal watchlist as a company showing signs of potentially serious problems.

In May 1989, department representatives met with First California's CEO to discuss various discrepancies noted in the company's 1988 annual statement. Among those items discussed were the steps First California was taking to strengthen a $2.1 million deficiency in its loss reserves reported as of December 1988. Finally, in June, the financial analysis division requested a special field examination of First California identifying as problem areas, asset valuations, affiliate transactions, losses, and the insurer's solvency. Department examiners completed their special examination in October 1989, determining that First California had deficiencies in both its loss and loss adjustment expense reserves amounting to $1.8 million as of June 30, 1989. The department also concluded that First California was insolvent by approximately $7 million as of the same date.

Since becoming the liquidator for First California, the commissioner has applied to the court for approval to retain counsel. If the court approves, counsel will investigate alleged violations of the California Insurance Code and other laws in connection with the operation of First California. Counsel will also determine what, if any, claims exist against the company's officers, directors, and affiliates. In addition, Colorado's deputy commissioner filed suit against First California's CEO, who was also the president of a Colorado insurance company. The suit alleges that the CEO, in his capacity as president of the Colorado insurer, converted assets for his own use and committed fraud. The suit seeks $400,000 plus interest and court costs.

The department detected shortages in First California's reserves as early as 1987. Thereafter, the department did not take any formal actions to ensure First California corrected the problem. Two years later, shortages in First California's loss and loss adjustment expense reserves made up more than $1.8 million of the company's nearly $7 million insolvency.

Homeland Insurance Company

Homeland Insurance Company

State of Domicile: California
Net premium written in 1985: $18 million
Status: liquidated September 1987

Hazardous Conditions Exhibited		Year First Noted
Questionable investments	☐	
Improper reinsurance	☐	
Improper affiliate transactions	☑	1982
Reserve deficiencies	☑	1982
Poor underwriting	☐	
Poor use of managing general agents	☐	
Agents' high balances	☐	

The factors that eventually led to the failure of Homeland Insurance Company (Homeland) were improper affiliate transactions and reserve deficiencies. While the California Department of Insurance (department) was able to detect these hazardous conditions well before Homeland's failure, it did not ensure the company took prompt and effective action to correct them. Following is a detailed presentation of those factors leading to Homeland's failure.

Improper Affiliate Transactions

The first indication the department had that Homeland's affiliate transactions were of concern came in February 1982 when the department completed its field examination of Homeland. The examination covered the period from September 15, 1979, to December 31, 1980. During the course of the examination, the department's examiners noted that Homeland jointly conducted its

operations with those of an affiliate, Homeland Industrial Corporation (HIC), which was a wholly owned subsidiary of Homeland's parent company. The examiners stated in their report that HIC administers claims, performs loss control and data processing services for self-insurers, and also handles the organization and management of insurance companies for others, known as "captive" companies. At the time of the examination, Homeland provided all the employees and performed all the services for HIC and billed HIC for its services.

As of December 31, 1980, HIC owed Homeland $55,000 for the services rendered on its behalf, and the examiners stated that the amount was growing because HIC had cash flow problems that precluded it from reimbursing Homeland. Homeland was in effect subsidizing HIC's operations. The examiners discussed this condition with Homeland's president, who indicated that HIC would receive adequate funding during 1982 to repay Homeland for its past services. The examiners recommended that a formal agreement be drawn up between Homeland and HIC outlining the duties and responsibilities of each party.

The department made no further reference to affiliate transactions until May 1985. At that time, the examiner reviewing Homeland's annual statement for 1984 referred to an amount owed to Homeland's affiliate as being questionable, but made no recommendation.

In April 1986, the department received a summary of the NAIC's review of key financial ratios computed from Homeland's 1985 annual statement. In addition to reporting that Homeland had seven ratios that fell outside normal industry ranges, the NAIC also noted that Homeland reported that amounts owed to it by its parent, subsidiaries, and affiliate totaled almost $1.3 million and represented 43 percent of reported surplus. The NAIC recommended that Homeland be accorded immediate regulatory attention, based, in part, on its affiliate transactions.

The department scheduled an examination of Homeland shortly after receiving the NAIC recommendation. In a May 1986 memorandum to the department, one of the examiners summarized his preliminary examination findings. Among the preliminary issues the examiner believed could adversely affect Homeland's surplus was the unsecured receivables of $1.3 million due from Homeland's parent and affiliates. In assessing Homeland's chances of collecting the amounts its affiliate and parent owed, the examiner stated that the 1984 consolidated equity for all the companies in the group, including Homeland, was only $580,000. Since Homeland's reported surplus was about $2.7 million for 1984, the examiner surmised that the remainder of the companies in the group, Homeland's affiliate and parent, had deficit financial positions. The examiner believed the group's financial position had worsened in 1985, and the likelihood of Homeland's collecting the amounts owed to it from the other group members was remote.

In June 1986, the examiner updated his preliminary findings in another memorandum to the department. Concerning affiliate receivables, the examiner stated that Homeland had misclassified $1.4 million due from an affiliate as "uncollected premiums." The examiner doubted whether this affiliate receivable, like the affiliate receivables identified in his May 1986 memorandum, could be collected. The amount of potentially uncollectible affiliate receivables examiners identified amounted to approximately $2.7 million as of December 31, 1985. If Homeland could not collect this amount, the company's reported 1985 surplus would be reduced to approximately $300,000 without considering any other potential examination adjustments.

A former insurance commissioner wrote to Homeland's president in June 1986 outlining the department's preliminary findings. The letter stated that, according to the department's analysis, a surplus infusion of as much as $5 million might be necessary to avoid regulatory action. The commissioner's letter requested Homeland's president provide a written plan on how such a surplus infusion was to be accomplished and submit the plan by June 30, 1986, or the department might not have any alternative but to issue a cease-and-desist order, restricting Homeland's ability to write new and perhaps renewal business.

Homeland's president responded on June 27, 1986, with his plan to secure the $5 million infusion the department recommended. His plan indicated Homeland was in the process of negotiating with one insurer that had offered to purchase a $2.5 million equity position in Homeland if the insurer's offer were matched by another insurer. Homeland was at that time trying to secure such a matching offer. The president also stated that another insurer was giving consideration to taking an independent equity position in Homeland without the matching requirement. According to Homeland's president, Homeland had supplied this insurer with its financial statements and the other material requested and was anticipating a final answer very soon.

In November 1986, Homeland's president sent a copy of a letter of intent from a potential buyer to the department concerning the proposed acquisition of Homeland and an affiliate. The intent letter specified that the exact terms of the sale would be agreed upon by December 1, 1986.

In January 1987, the department's examiner once again updated the department on the progress of the examination of Homeland. The examiner had extended his examination to cover the period ended June 30, 1986. As of that date, the examiner had found Homeland to be insolvent by approximately $2 million. The examiner further stated that Homeland had located a prospective buyer who had agreed to put $5 million in additional funding into the company. It was the examiner's understanding that the prospective buyer and Homeland's representatives were to meet with department officials later in the week. In closing, the examiner stated that he would further update the results of the examination to December 31, 1986, and prepare a pro forma balance sheet should the additional funding be received before the completion of his fieldwork.

After examiners reviewed Homeland's 1986 annual statement and performed an actuarial analysis of the insurer's loss reserves, the former insurance commissioner informed Homeland's president in March 1987 that the department found Homeland to be insolvent by more than $3 million as of December 31, 1986. The

former commissioner advised the president that if the company did not infuse or have a firm commitment to infuse $8 million in capital into Homeland in a form acceptable to the department on or before March 20, 1987, the department would have no choice but to seek an order of conservatorship.

In a memorandum dated March 24, 1987, to Homeland's president, the former commissioner summarized the agreements reached in a meeting held on March 20, 1987. Present at the meeting were department representatives and Homeland's president and prospective buyers. The former commissioner reiterated the department's requirements for recapitalizing Homeland and the deadlines that had to be met to effect the recapitalization. The requirements included an infusion of more than $5.2 million to restore Homeland's statutory solvency. In addition, the former commissioner stated that an executed letter of intent for the acquisition and recapitalization of Homeland was to be delivered to her no later than March 27, 1987. Further, a letter of credit equal to the amount of cash to be infused was to be placed into escrow upon the execution of the letter of intent. Finally, an application form was to be filed with the department no later than April 9, 1987, that would include the definitive agreement to acquire and recapitalize Homeland. The former commissioner cautioned in her letter that failure to meet any of the department's requirements would prompt the commissioner to seek a conservatorship order.

At the end of March 1987, the department's examiner sent in his final estimate of Homeland's financial condition as of December 31, 1986. As of that date, his examination showed that Homeland's insolvency had grown to $3.5 million. Apparently, the prospective buyer who attended the meeting on March 20, 1987, with the department either could not or would not meet the department's requirements because, on April 6, 1987, another meeting was held with department representatives and attended by another prospective buyer. In summarizing the results of that meeting, the chief of the financial analysis division stipulated several conditions that Homeland and the prospective buyer had to meet to avoid a conservatorship order.

The conditions the department imposed on Homeland included requiring the prospective buyer to place funds or a letter of credit in the amount of $6 million into escrow on or before April 24, 1987. As of the close of escrow, the $6 million was to be infused into Homeland. The department also required that, before escrow was to open, the department must approve the form of the funds and the terms of the escrow. Further, Homeland was to immediately agree to voluntary supervision by the department. Such supervision would require department personnel be added as signatories on all Homeland's bank accounts. In addition, Homeland was to immediately discontinue writing any new business. Moreover, the acquisition and recapitalization of Homeland was to be completed by June 1, 1987. Finally, if the prospective buyer decided at any time not to pursue the acquisition of the company, the department was to be notified immediately.

On April 23, 1987, the prospective buyer wrote to the department requesting that the deadline for the placement of $6 million in funds or a letter of credit in that amount into escrow be extended until May 1, 1987. On May 1, 1987, the chief of the financial analysis division contacted the proposed buyer and learned that some issues relating to the acquisition and recapitalization of the company remained unresolved. He, therefore, advised the former commissioner to proceed with the conservatorship of Homeland. The former commissioner was appointed conservator of Homeland on May 6, 1987.

The department did not take prompt and effective action when it detected problems with improper affiliate transactions involving Homeland and an affiliate company. Although the department had first detected this problem during an examination completed in February 1982, it failed to take the steps necessary to follow up its recommendation that Homeland refrain from subsidizing its affiliate and that the company execute a written agreement between the two parties outlining the duties and responsibilities of each. Instead, the department relied on the promise of Homeland's president that sufficient funds would be provided to Homeland's affiliate to allow it to reimburse the insurer during 1982. This promise was never fulfilled, and the department did not take any

further action until June 1986 when examiners found unsecured receivables due from Homeland's parent and affiliates amounting to approximately $2.7 million. The examiners believed that neither the parent nor the affiliates of the holding company to which Homeland belonged had sufficient resources to repay the insurer.

Reserve Deficiencies

The department granted Homeland a certificate in 1979 authorizing it to transact workers' compensation insurance business in California. In February 1982, department examiners completed an examination of Homeland as of December 31, 1980. The examiners tested Homeland's reserves for reported losses and for incurred but unreported losses and found both to be inadequate. However, the examiners did not require Homeland to increase its reserves because they stated that, even though their testing indicated a $100,000 shortage existed in reported loss reserves, Homeland had established an $87,000 reserve for another purpose that would offset the majority of the deficiency. As for Homeland's reserve for incurred but unreported losses, the examiners stated that, although their testing indicated the reserve was inadequate, a lack of available data precluded them from calculating the actual shortage and, therefore, from increasing the reserve. Furthermore, the examiners stated Homeland was in the process of substantially strengthening its reserves for unreported losses for the year ended 1981.

In March 1982, the department received the NAIC's report of key financial ratios computed from Homeland's 1981 annual statement. The report showed one ratio above industry norms. This ratio indicated Homeland had experienced a large increase in the amount of premiums it wrote in 1981 over the previous year. Such an increase could mean the company was entering into new sales territories or it might be a sign the company was attempting to increase cash income to meet loss payments if its reserves were deficient.

In response to Homeland's application to amend its certificate of authority to allow it to market other lines of insurance, the chief of the financial analysis division wrote to Homeland's president in January 1983. The chief requested certain information from the insurer after reviewing its 1981 annual statement and its September 1982 quarterly statement. Among other questions, the department asked the president to explain the apparent inadequacy of Homeland's 1981 loss reserves.

Homeland responded to the department's question concerning its reserves in March 1983. The company believed it had furnished an incorrect figure in its September 1982 quarterly statement. Further, once the department had reviewed Homeland's 1982 annual statement, Homeland believed the department would conclude that the loss reserving practices Homeland used during 1981 were more accurate than the department had previously found.

Between April 1983 and April 1985, the NAIC's reports of key financial ratios computed from Homeland's 1982, 1983, and 1984 annual statements showed the insurer as consistently being above the normal range in the amount of premiums it wrote compared with the previous year's premiums. Furthermore, Homeland appeared on the department's internal watchlist four times between 1982 and 1985 under the "watch" category. According to the department's definition, a watch company is one that exhibits signs of potentially serious problems. Despite Homeland's warning signs, we found no indication the department increased its surveillance until April 1986. At that time, the department received the NAIC's report of key financial ratios for Homeland's 1985 annual statement. The report stated Homeland had seven ratios that were unusual compared with industry averages. Two of the unusual ratios indicated potential deficiencies in Homeland's loss reserves. In the NAIC's opinion, Homeland needed immediate regulatory attention.

One of the department's examiners called for an immediate field examination of Homeland in April 1986. Two months later, in June 1986, a former commissioner wrote to Homeland's president after the department had reviewed Homeland's quarterly statement dated March 31, 1986, and had received a preliminary report from its field examiners. Among the other issues discussed in the commissioner's letter was that the department's analysis indicated that Homeland's reserves for prior year losses and loss adjustment expenses were deficient by at least $1 million. A former commissioner stated that, based on the department's analysis, Homeland might need a capital infusion of as much as $5 million to overcome its loss deficiencies and other noted problems.

In November 1986, one of the department's senior casualty actuaries increased the estimate of the shortage in Homeland's reserves. Based on his analysis as of June 30, 1986, the department's actuary estimated the total deficiency for loss and loss adjustment expense reserves was more than $3 million.

Although the department never published its last examination report of Homeland, one of its examiners advised the department in March 1987 that, as of December 31, 1986, Homeland was insolvent by $3.5 million. In May 1987, the former commissioner was named as Homeland's conservator.

Between 1982 and 1985, the department was aware that Homeland was expanding its business and that the insurer's reserves were consistently inadequate. However, during these four years, the department did not take any formal regulatory actions against Homeland until it found the company had a reserve deficiency of approximately $1 million as of March 31, 1986. In November 1986, one of the department's actuaries revised the reserve shortage to more than $3 million as of June 30, 1986.

Ideal Mutual Insurance Company

Ideal Mutual Insurance Company

State of Domicile: New York
Net premium written in 1983: $28.5 million
Status: liquidated January 1985

Hazardous Conditions Exhibited		Year First Noted
Questionable investments	☐	
Improper reinsurance	☑	1980
Improper affiliate transactions	☐	
Reserve deficiencies	☑	1980
Poor underwriting	☐	
Poor use of managing general agents	☑	1980
Agents' high balances	☐	

Ideal Mutual Insurance Company (Ideal) is domiciled in New York and licensed to do business in California. The factors that eventually led to the failure of Ideal were improper reinsurance, reserve deficiencies, and the poor use of managing general agents. While the California Department of Insurance (department) was able to detect these hazardous conditions well before Ideal's failure, it did not ensure the company took prompt and effective action to correct them. Following is a detailed presentation of those factors leading to Ideal's failure.

Improper Reinsurance

Because Ideal was domiciled in New York, the New York Insurance Department scheduled all field examinations of Ideal. The department learned that Ideal's reinsurance might be an area of concern as early as June 1980 when the department received

New York's field examination report for Ideal covering the three years ended December 31, 1977. The New York examiners reported Ideal was reinsuring almost 27 percent of its total direct premiums written, principally with unlicensed insurers located outside the United States. According to the California Insurance Code, for an insurer to reduce the reserve for estimated losses associated with the business ceded to unlicensed reinsurers, the primary insurer must prove to the insurance commissioner that the unlicensed reinsurers meet the financial requirements and maintain the same standards as an insurer licensed to do business in this state. In lieu of demonstrating such proof, the code allows the primary insurer to withhold funds or obtain letters of credit from unlicensed reinsurers in amounts equal to the unearned premium and total estimated losses associated with the risks reinsured. However, we found no evidence that the department contacted either New York's department or Ideal to satisfy itself that the reinsurance placed with unlicensed insurers was proper according to California law.

In March 1981, the NAIC sent the department its report analyzing key financial ratios computed from Ideal's 1980 financial statement. The NAIC noted that, in addition to having six unusual ratios, Ideal showed a liability in its statement captioned "payable to pool" that amounted to 40 percent of its total liabilities. In other words, almost half of everything Ideal owed was to a reinsurance pool. The NAIC recommended immediate regulatory attention be accorded Ideal. This information should have alerted the department to the fact that Ideal had a significant commitment to a reinsurance pooling agreement. Although the department did put Ideal on its own watchlist in January 1982, we found no indication in the department's files that Ideal received any additional regulatory attention at that time.

In August 1983, the department received a draft copy of an examination report of Ideal conducted by New York for the three years ended December 31, 1980. In a draft letter to Ideal's legal counsel summarizing the report's findings, a former California commissioner stated that the New York examiners' preliminary results found Ideal to be insolvent by $7.4 million primarily

because of problems with Ideal's reinsurance arrangements. The letters of credit Ideal used to secure the amounts owed the company from unlicensed reinsurers were not sufficient in amount. According to the New York report, Ideal only obtained letters of credit representing the amounts of unearned premiums and paid or reported losses, not the amounts estimated as necessary to cover incurred but unreported losses associated with the business Ideal reinsured. This fact alone prompted the New York examiners to reduce Ideal's surplus by $14.1 million. Based on the information contained in the 1980 examination report, the department delayed approval of Ideal's request for an amendment to its certificate of authority that would have allowed Ideal to market additional lines of insurance in California. A former commissioner stated that the department would continue to consider Ideal's request if the insurer increased the amounts of its letters of credit and ensured that they conformed to the department's standards. The commissioner closed the draft letter by saying that, if the department failed to receive such commitments from Ideal, the department would not only deny the pending application for an amended certificate but would also take further regulatory action, which might affect the company's ability to operate in California. However, we found nothing in the department's files indicating that Ideal had made such commitments or that the department followed through with any formal regulatory action at that time.

In March 1984, the department received the final version of New York's field examination report of Ideal covering the three years ended December 31, 1980. The examiners reported that, at December 31, 1980, Ideal was insolvent and that the prime cause for the insolvency was that Ideal had underreported its liability for unauthorized reinsurance by approximately $23 million. A significant portion of the liability represented reinsurance placed with Optimum Insurance Company of Illinois, one of Ideal's affiliates. Although the department did not receive the finalized version of the field examination report from the New York Insurance Department until 1984, the California Department of Insurance had its own examiner participating in the examination and, thus, should have had some knowledge of Ideal's financial condition during the course of the examination.

After reviewing Ideal's September 1984 quarterly financial statements, one of California's examiners wrote to Ideal's president in November 1984 and requested Ideal either voluntarily cease writing business in California immediately or infuse additional funding to increase the amount of its surplus. The letter also requested a response within three weeks, but we could find no such response in the department's files.

In December 1984, the department received another field examination report of Ideal from New York covering the three years ended December 1983. The examination found Ideal to be insolvent by more than $155 million and indicated the company underreported its liability for unauthorized reinsurance by approximately $120 million. Again, as was reported in the 1980 field examination, the majority of the liability represented reinsurance placed with Optimum Insurance Company of Illinois. California issued a cease-and-desist order against Ideal the day after New York placed it in rehabilitation.

The department found that Ideal placed a significant amount of reinsurance with unlicensed insurers as early as 1980. Although Ideal's financial condition continued to deteriorate, the department took no formal regulatory action, based on our review, to ensure that Ideal corrected its use of improper reinsurance arrangements until more than four years later, in December 1984, when the department issued a cease-and-desist order against the company in California. At that time, New York examiners had found Ideal to be insolvent by more than $155 million with approximately $120 million of that amount the result of improper reinsurance.

Poor Use of Managing General Agents

In June 1980, the department received New York's field examination report of Ideal covering the three years ended December 31, 1977. New York's examiners found that Ideal wrote aviation insurance through a managing general agent and, then, ceded 95 percent of the risk principally to unauthorized reinsurers located outside the United States. Further, the New York

examiners also reported that Ideal was engaged in another underwriting program designed to service unauthorized reinsurers located outside the United States. Under this program, Ideal wrote policies for risks within the United States and, subsequently, would cede substantially all of the risk to an unauthorized reinsurer located in Bermuda. These two underwriting programs represented almost 27 percent of the total premiums written by Ideal in 1977, and according to the examiners, both appeared to be fronting arrangements considered illegal by the New York Insurance Department.

Fronting arrangements allow companies not licensed to transact insurance business within a given state the ability to transact that business without regulatory oversight. Fronting is made possible when a licensed company, such as Ideal or its managing general agent, underwrites business in its own name and, then, cedes substantially all the risk associated with that business to an unlicensed company for a fee. The examiners concluded that, as of July 1979, the New York department was still reviewing the issue of fronting by Ideal, and no final regulatory decision would be made at that time. We could find no documentation that the California department contacted either the New York department or Ideal to determine what the resolution was concerning the fronting arrangements.

The California department, though not the domicile state for Ideal, still received annual copies of Ideal's financial statements and the NAIC's analysis of Ideal's financial ratios. In fact, in 1981 and 1982, the NAIC reported that several of Ideal's financial ratios were outside of industry norms. These ratios indicated possible deficiencies in loss reserves, inadequate liquid assets to meet financial demands, and disproportionately high balances for agents. As a result, in 1981 and again in 1982, the NAIC recommended that Ideal be given immediate regulatory attention. However, although Ideal appeared on the department's watchlist during 1982 and 1983, indicating more intensive scrutiny should be given, we could find no evidence that the department increased its monitoring effort regarding Ideal at that time. To the contrary, we found no record that the department had completed any financial reviews of Ideal's statements between 1977 and 1983.

According to an internal department document, by August 1983, the department had received a preliminary draft of New York's examination of Ideal as of December 1980. The New York examiners had initially found Ideal to be insolvent by approximately $7.4 million. The amount was later revised in the final report to an insolvency of $6.5 million. The California department used this information in denying Ideal's application for an amended certificate of authority to transact additional insurance business in California. The application was already pending, and the department took no further regulatory action at that time. The amended certificate of authority would have allowed Ideal to write additional lines of insurance business in California.

In March 1984, the department received the final version of New York's field examination report of Ideal covering the three years ended December 31, 1980. The examiners reported that, as of December 31, 1980, Ideal was insolvent primarily because Ideal had underreported its liability for unauthorized reinsurance by approximately $23 million. A significant portion of the liability represented reinsurance placed with an affiliate, Optimum Insurance Company of Illinois, a wholly owned affiliate of Optimum Holding Company. Optimum Holding Company, a subsidiary of Ideal, was formed to act as Ideal's managing general agent. Although the department did not receive the finalized version of the field examination report from the New York Insurance Department until 1984, the California Department of Insurance had its own examiner participating in the examination and, thus, should have had some knowledge of Ideal's financial condition during the course of the examination.

After reviewing Ideal's September 1984 quarterly financial statements, one of California's examiners wrote to the company's president in November 1984 concerning Ideal's deteriorating financial condition. The examiner warned that Ideal's surplus had fallen by 28 percent and was insufficient to support the volume of premiums being written. In addition, the examiner requested that Ideal either voluntarily cease writing business in California immediately or infuse additional funding to increase the amount of its surplus. The letter also requested a response within three weeks, but we could find no such response.

In December 1984, the department received another field examination report of Ideal from New York covering the three years ended December 1983. The examination found Ideal to be insolvent by more than $155 million. The examination indicated that Ideal underreported its liability for unauthorized reinsurance by approximately $120 million. Again, as was reported in the 1980 field examination, a significant portion of the liability represented reinsurance placed with Optimum Insurance Company of Illinois, a subsidiary of Ideal's managing general agent. California issued a cease-and-desist order against Ideal days after New York placed it in rehabilitation.

As early as 1980, the department found that Ideal made questionable use of managing general agents to develop its business and to reinsure business with third party reinsurers. Although Ideal's financial condition continued to deteriorate, the department, based on our review, took no formal regulatory action requiring Ideal to control its managing general agents until more than four years later, in December 1984. At this time, the department issued a cease-and-desist order against the company in California when the New York examiners found Ideal to be insolvent by more than $155 million. Approximately $120 million of this amount was the result of unauthorized reinsurance, and the majority of the reinsurance was placed with a wholly owned subsidiary of Ideal's managing general agent.

Reserve Deficiencies

The department learned that Ideal had deficiencies in its reserves in June 1980 when it received New York's examination report for the three years ended December 31, 1977. As a result of the examination, Ideal's adjusted surplus was $4 million, or $2.2 million less than the amount the company originally reported. The New York examiners required Ideal to increase its loss and loss expense reserves by a total of $2.1 million. Of the total increases required, the examiners required loss reserves to be increased by $1.1 million mainly because Ideal had not properly adjusted its reserves for its share of workers' compensation losses

associated with the reinsurance pool Ideal was participating in. In addition, the examiners required the reserve for loss adjustment expenses to be increased by $1 million, in part, because Ideal had not included incurred but unreported losses in estimating its loss adjustment expense reserves, as both New York and California law require.

In March 1981 and 1982, the department received ratio reports from the NAIC showing key financial ratios from Ideal's 1980 and 1981 annual statements. The purpose of these reports is to compute certain financial ratios and compare them with industry standards. Among the ratios computed are three related to the adequacy of the insurer's reserves. The NAIC reported that, in 1981 and again in 1982, all three of the reserve ratios for Ideal were abnormal according to industry standards, indicating potential deficiencies. Even though the NAIC recommended immediate regulatory attention be accorded Ideal in its 1981 and 1982 reports, we could find no indication the department conducted any annual or quarterly reviews of Ideal's financial statements between 1977 and 1983.

In August 1983, the department learned the preliminary results of New York's field examination of Ideal covering the three years ended December 31, 1980. Among other adjustments required as a result of the examination, the New York examiners instructed Ideal to increase its loss and loss adjustment expense reserves by a total of $8.9 million.

In November 1984, one of the department's examiners wrote to Ideal's president asking that the company voluntarily cease writing business in California or infuse additional surplus into the company. The department made this request because of adverse financial trends disclosed in its review of Ideal's September 1984 quarterly statement. The letter also asked for Ideal's response within three weeks. However, we found no such response in the department's files.

In December 1984, New York issued another examination report of Ideal covering the three years ended December 31, 1983. The examination found Ideal to be insolvent by $155 million, $26 million of which was attributable to reserve deficiencies. On December 28, 1984, the department issued a cease-and-desist order against Ideal, barring it from transacting any new or renewal business in California, except for business that Ideal was contractually mandated to renew, and in January 1985, a former commissioner placed Ideal in conservation.

The department learned that Ideal had insufficient reserves as early as June 1980. Although Ideal continued to show signs of deficiencies in its reserves during the next four years, as noted in the NAIC's ratio reports and subsequent examinations conducted by New York, based on our review, the department did not increase its monitoring effort or take an active role in getting Ideal to correct its problems with reserves until it issued a cease-and-desist order against Ideal days after New York placed the company into rehabilitation.

Integrity Insurance Company

Integrity Insurance Company

State of Domicile: New Jersey
Net premium written in 1985: $111.3 million
Status: liquidated March 1987

Hazardous Conditions Exhibited		Year First Noted
Questionable investments	☐	
Improper reinsurance	☑	1981
Improper affiliate transactions	☐	
Reserve deficiencies	☑	1981
Poor underwriting	☐	
Poor use of managing general agents	☑	1981
Agents' high balances	☐	

The factors that contributed to the failure of Integrity Insurance Company (Integrity) were improper reinsurance, reserve deficiencies, and poor use of managing general agents. While the California Department of Insurance (department) was able to detect these hazardous conditions well before Integrity's failure, it did not ensure the company took prompt and effective action to correct them. Following is a detailed presentation of those factors leading to Integrity's failure.

Improper Reinsurance

Integrity's state of domicile was New Jersey and, therefore, the New Jersey department of insurance would normally schedule all examinations of its financial condition. The California Department of Insurance placed Integrity into conservatorship in January 1987 after New Jersey obtained an order of rehabilitation for the

company. Before that action, the department was aware that Integrity had a history dating back to the late 1970s of noncooperation and failing to fully comply with the commitments it made to the department. Furthermore, as early as 1981, the department was aware Integrity had problems with reinsurance through its review of Integrity's annual statement. However, the department did not take regulatory action until May 1986.

Specifically, between 1978 and 1979, the department had extensive correspondence with Integrity regarding the insurer's application for an amendment to its certificate of authority. The amendment was necessary for Integrity to market new lines of insurance in California. While reviewing Integrity's application, the department requested a variety of information about the insurer's financial condition. However, according to department files, Integrity repeatedly either ignored requests for information or failed to correct the information reported in its statements. Because of Integrity's continued failure to comply fully with the department's requests, the department fined the company $25,000 in 1979. The stipulation-and-waiver order stated that Integrity's past actions may indicate inadequate management control over the preparation of its annual statements and an absence of appreciation for complying with California's requirements and requests from the department and commissioner. However, in spite of the fine and the lack of compliance with the department's requests for information, the department issued the amended certificate.

In March 1981, after reviewing Integrity's 1979 annual statement, a department examiner noted that the company had reinsured with 22 additional reinsurers that were not admitted to transact business in California. Also, from 1983 through 1986, the National Association of Insurance Commissioners' (NAIC) reports analyzing key financial ratios computed from Integrity's annual statements indicated that Integrity had a substantial amount of unauthorized reinsurance and that a large amount of this unauthorized reinsurance was with reinsurers located outside the United States.

The NAIC's analyses from 1981 through 1986 also showed a consistently unusual result in Integrity's ratio for surplus aid to surplus. This ratio attempts to measure the beneficial effect on surplus caused by an insurer's use of reinsurance. According to the NAIC's interpretation, an unusual result for this ratio may indicate that the insurer's surplus is inadequate and might cause enough of an improvement in the results calculated for its other ratios to conceal important areas of concern. The NAIC advises a regulator to thoroughly analyze an insurer's reinsurance agreements to determine their legitimacy whenever the results of an insurer's ratio for surplus aid to surplus is unusual. Moreover, other than a summary of an examination report for the year ended December 31, 1975, and one examination report of the company covering the five years ended December 31, 1980, we could not find any evidence that the department received any information from Integrity's state of domicile, New Jersey, that might have aided in the department's monitoring effort.

During 1985, the insurance analyst, A.M. Best, lowered its quality rating of Integrity because a substantial portion of the company's business was placed with reinsurers not licensed in the United States or without an A.M. Best rating. In May 1986, the department instructed Integrity to voluntarily cease writing any new or renewal business in California except for two lines generating approximately $250,000 in monthly premiums. The department took this action, in part, because of doubts concerning the company's ability to collect approximately $48 million owed to Integrity by two financially troubled companies. In July 1986, the department's review of Integrity's 1985 annual statement revealed that nine of the reinsurers Integrity dealt with were either in conservatorship, liquidation, or under cease-and-desist orders. The status of these reinsurers jeopardized the collectability of $55.5 million in reinsurance owed to Integrity. The analysis also noted that Integrity did not secure a deposit or a letter of credit for a $4 million reinsurance credit the company claimed for a nonadmitted reinsurer. The analysis indicated that if this reinsurance credit and the $55.5 million was in jeopardy of collection, Integrity would have a deficit in its reported capital and surplus of $39 million. Therefore, the company would be

insolvent. Nevertheless, the department allowed Integrity to continue marketing the agreed on two lines of insurance until September 1986. At that time, the department found that, in July 1986, Integrity had reported premiums of $1.6 million, far in excess of the agreed premium amount of $250,000 per month. As a result, the chief of the financial analysis division recommended the former commissioner issue a cease-and-desist order against Integrity. Before a formal order was initiated, however, Integrity agreed to voluntarily cease all business in California. The former commissioner finally applied for and received a court order appointing her conservator of Integrity in January 1987.

The department detected potential problems with Integrity's reinsurance as early as 1981. Further, the department knew that, dating back to the late 1970s, Integrity had a history of noncooperation and failing to comply with the commitments it made to the department. However, the department did not take any regulatory actions to correct the deficiencies noted in Integrity's reinsurance practices until May 1986 when the department instructed Integrity to voluntarily cease writing new or renewal business in California. Eight months later, the department received authority to conserve Integrity after determining the company was insolvent, in part, because of uncollectible reinsurance.

Reserve Deficiencies

In March 1981, the department's review of Integrity's 1979 annual financial statement indicated Integrity's loss and loss expense reserves were deficient for 1976, 1977, and 1979. The department concluded the company should be watched closely. Further, in April 1981, the NAIC recommended that regulatory attention be targeted toward Integrity's loss reserves. In October 1981, the department noted that Integrity had grown rapidly from 1976 through 1980 and that the company's reported underwriting gains were unrealistic.

In March 1982, the NAIC's financial ratio report on Integrity for 1981 showed Integrity's ratio for liabilities to liquid assets was unusually high. The NAIC handbook on ratio interpretation

recommends that an insurer with a high ratio in this category be analyzed further for the adequacy of its reserves. However, despite indications that Integrity had problems with its reserves beginning in the late 1970s, the department did not take any regulatory action to address this concern.

In March 1983, the NAIC's financial ratio report on Integrity for 1982 again showed that Integrity's ratio for liabilities to liquid assets had worsened. The NAIC analysis showed that the ratio was nearly two to one, indicating Integrity might be experiencing cash flow problems. The analysis recommended Integrity be accorded regulatory attention. Once again, throughout 1983, the department did not initiate any action to ensure Integrity's reserves were adequate.

In March 1984, the NAIC's financial ratio report on Integrity for 1983 showed that Integrity's ratio for liabilities to liquid assets was still high and that Integrity's ratio for change in premiums written was above the usual range. The NAIC handbook on ratio interpretation notes that large fluctuations in the amount of premiums written might indicate instability within an insurance company. In addition, a major increase in this ratio may signal an insurer's abrupt entry into new lines of business or sales territories. Further, if the increase in written premiums is accompanied by a shift to the liability lines of business, the problem could be more serious because shifts to liability lines could be a short-term solution to paying current claims but would not address the underlying problems and could quickly increase the risk of insolvency. Again, the NAIC analysis recommended that regulatory attention be directed at Integrity's reserve deficiencies although the department did not apply such attention.

In March 1985, the NAIC's financial ratio report on Integrity for 1984 showed that Integrity's reserves again appeared deficient. The NAIC handbook on ratio interpretation recommended that further analysis be directed toward determining which lines of business caused the deficiency and if the deficiency was the result of a deliberate understatement of losses. Further, the NAIC analysis for the third year in a row recommended that regulatory attention be directed at Integrity's loss reserves although, again, the department did not apply such attention.

In March 1986, the NAIC financial ratio report on Integrity for 1985 showed that Integrity had 10 of 11 financial ratios that the NAIC computes as falling outside the usual range of values. The NAIC analysis recommended that immediate regulatory attention be directed at Integrity's loss reserves. Subsequently, in April 1986, Integrity explained to the department that several of its NAIC financial ratios were outside the usual range because of a decrease in Integrity's surplus. It further explained that the main reason for the decrease in surplus was that Integrity had increased its reserves by $23 million during that year. When Integrity realized that its premium volume was too high in relation to its surplus, it also reduced its premium volume. However, the reduction was not enough to bring its premium-to-surplus ratio down to a level considered usual. Integrity stated that it wanted to increase its surplus by raising additional capital.

In May 1986, the chief of the financial analysis division informed a former commissioner that he had advised Integrity to voluntarily cease and desist doing business in California or the department would initiate formal cease-and-desist proceedings against the company. Integrity responded to the department by stating that it voluntarily agreed to cease writing all new business but requested the department allow it to continue servicing two programs. The department agreed to allow Integrity to maintain the two programs but reiterated that Integrity cease writing all other new and renewal business in California.

In July 1986, the department's review of Integrity's 1985 annual financial statement revealed that Integrity was underreserved by approximately $34 million. In September 1986, the chief of the financial analysis division recommended to the former commissioner that an immediate cease-and-desist order be issued against Integrity because the company had violated its voluntary cease-and-desist agreement by writing $1.6 million in premiums during July 1986 in California.

In October 1986, in response to the department's concerns, Integrity explained in a letter that the two programs the department allowed Integrity to maintain had a substantial volume of business in July and agreed to cut back on the business if the department believed it was necessary. Integrity further informed the department that it had signed a letter of intent that called for a contract with a group of investors to make a $50 million capital contribution to Integrity's parent company. The money would immediately be made available to Integrity as additional capital. In a second letter, also written in October 1986, Integrity agreed to immediately cease writing all new and renewal business in California, including the two programs the department had previously allowed the insurer to continue servicing.

In view of Integrity's letters to the department, the chief of the financial analysis division informed the former commissioner that the department could hold off on issuing a formal cease-and-desist order against the company. The chief concluded that, if the bailout failed, the department could then proceed with a formal cease-and-desist order or even conservatorship.

In November 1986, the New Jersey insurance commissioner issued a memorandum to all insurance commissioners informing them that on November 14, 1986, the New Jersey Department of Insurance and Integrity entered into a consent order allowing Integrity 30 days to finalize negotiations for a capital infusion sufficient to address the impairment of Integrity's financial condition. The order stipulated that the New Jersey insurance commissioner would proceed to rehabilitate the company if the negotiations failed. The New Jersey insurance commissioner also requested that each state authority not take any immediate action to revoke Integrity's license until the possibility of obtaining additional capital for the company had been fully explored. On December 30, 1986, the New Jersey insurance commissioner obtained an order of rehabilitation for Integrity. On January 5, 1987, the former California commissioner was appointed conservator of Integrity in California.

Despite its own analyses and those of the NAIC showing that Integrity had a history of shortages and problems with its reserves beginning in the late 1970s and continuing until the company was placed into conservation in 1987 in California, the department did not take any formal regulatory actions requiring Integrity to correct its problems with reserves.

Poor Use of Managing General Agents

Although the department was aware of Integrity's lack of control over one of its managing general agents as early as 1981, it did not take any substantive regulatory action to improve Integrity's supervision of its managing general agents until May 1986.

In March 1981, a department examiner, summarizing the issues contained in New Jersey's examination of Integrity as of December 31, 1975, noted that the New Jersey examiners found that Integrity appeared to have inadequate control over the loss reserves of one of its managing general agents and recommended that periodic audits be conducted of the agent. Also, in March 1981, the department's review of Integrity's 1979 annual statement showed that Integrity's premium writings had increased by 81 percent and its agents' balances had also increased significantly. (An insurer establishes an account entitled "agents' balance" to record amounts owed the company by its agents for the premiums they collect on the insurer's behalf.) The examiner noted that these two factors, combined with Integrity's history of shortages in loss and loss expense reserves, put Integrity into a "close watch" category. In April 1981, the NAIC issued its report of key financial ratios relating to Integrity's 1980 annual statement. The ratio report indicated that Integrity's ratio of agents' balance to surplus was above the industry's usual range of values. The NAIC recommended that Integrity receive targeted regulatory attention directed toward Integrity's loss reserves and its agents' balance. However, we could not find any evidence the department increased its regulatory efforts concerning Integrity in spite of the information provided by its own analysis and that of the NAIC.

In October 1981, as part of the department's review of Integrity's application to expand the type of business it wrote in California to include workers' compensation, a department examiner noted that, between 1976 and 1980, the company's premiums had grown from $15 million to $98 million, its use of managing general agents had increased from one to 23, and its reported underwriting profits appeared unrealistic. The examiner also noted that, in 1978, when Integrity had last applied for the authority to increase the types of business it could write in California, he had recommended the application be denied. However, instead of denying Integrity's request, a former commissioner had simply fined the company $25,000 and granted the application. The examiner suggested the department request that the New Jersey examiners augment their current field examination of Integrity to include special emphasis on Integrity's reinsurance arrangements and its monitoring efforts directed toward its managing general agents. In New Jersey's examination report of Integrity as of December 1980, the examiners described in detail Integrity's use and control of its managing general agents. However, we saw no evidence that the New Jersey examiners placed any special emphasis on Integrity's extensive use of reinsurance, largely established by Integrity's managing general agents.

Between 1982 and 1984, the NAIC issued its reports of key financial ratios relating to Integrity's annual statements for 1981, 1982, and 1983. According to those reports, Integrity exceeded the usual range in its ratio of agents' balance to surplus for all three years reviewed. The NAIC also expressed concern about Integrity's loss reserves in 1983 and 1984 and the quantity and quality of its reinsurance in 1984. Despite these indicators from the NAIC and the department's own review, we could not find any evidence that the department made an effort to evaluate Integrity's control over its managing general agents beyond reviewing the information included in the New Jersey examination report. Although the information provided to the department demonstrated a potential problem with Integrity's use of managing general agents, the department did not query the insurer concerning its use of managing general agents and take appropriate regulatory actions against Integrity.

According to a report by the United States House of Representatives' Committee on Energy and Commerce and the testimony of Integrity's receiver, Integrity had agreements with approximately 80 managing general agents who were essentially independent operatives with authority to appoint subagents, issue Integrity's policies, collect premiums, and arrange reinsurance. Some of Integrity's managing general agents were also authorized to adjust and pay claims and to establish loss reserves. The receiver for Integrity told the committee that Integrity failed to install an adequate information system to monitor the diverse lines of business its managing general agents generated. The receiver estimated that the net cost of Integrity's failure would be $300 million or more.

The department was aware of Integrity's lack of control over its managing general agents as early as 1981. In spite of continued indications of Integrity's extended use of managing general agents and rapid growth in the amount of premiums written for the company, the department waited until May 1986 before instructing Integrity to voluntarily cease writing new and renewal business in California. Eight months later, the department obtained an order of conservatorship for Integrity in response to the company's insolvency caused, in part, by the volume of business Integrity's managing general agents wrote.

Midland Insurance Company

Midland Insurance Company

State of Domicile: New York
Net premium written in 1985: $48.1 million
Status: liquidated May 1986

Hazardous Conditions Exhibited		Year First Noted
Questionable investments	☐	
Improper reinsurance	☑	1974
Improper affiliate transactions	☐	
Reserve deficiencies	☑	1980
Poor underwriting	☐	
Poor use of managing general agents	☐	
Agents' high balances	☐	

Midland Insurance Company (Midland) is domiciled in New York and licensed to do business in California. The factors that contributed to the failure of Midland were improper reinsurance and reserve deficiencies. While the California Department of Insurance (department) was able to detect these hazardous conditions well before Midland's failure, it did not ensure the company took prompt and effective action to correct them. Following is a detailed presentation of those factors leading to Midland's failure.

Improper Reinsurance

The department began questioning Midland's reinsurance arrangements as early as May 1974. In his review summary of Midland's 1973 annual statement drafted at that time, one of the department's examiners had concerns involving Midland's

reinsurance. He noted that Midland had ceded $3.3 million to a newly formed reinsurance subsidiary company located in Bermuda. Midland did not disclose that this reinsurance company was a subsidiary in its 1973 annual statement filed with the department. The purpose of reinsurance is to allow the insurer to spread portions of the risks it underwrites to other insurers in exchange for a portion of the premiums it collects from policyholders. In this way, the original insurer can reduce the amount it would have to pay to its policyholders should the perils originally underwritten actually occur. In that event, the original insurer would pay the losses associated with the business it retained, and the reinsurer would pay the losses on the business it assumed. However, by ceding business to a reinsurer that is a subsidiary, Midland did not spread the risk of loss outside the holding company system of which it was a part.

In addition, Midland had reported $8.1 million as the amount ceded to another reinsurer, but a verification of this reinsurer's statement revealed that only $6.6 million was reflected as assumed business from Midland. The examiner felt that, because of these facts, Midland's reinsurance program warranted a closer review. However, we could find no indication the department questioned Midland about the reinsurance placed with its subsidiary or the discrepancy between the amount of reinsurance ceded per Midland's statement and the amount assumed per the reinsurer's statement.

In May 1977, the California department's chief examiner received the file memoranda from the New York Insurance Department regarding the results of its examination of Midland for the period ended December 31, 1975. One memorandum, dated May 9, 1977, written to the first deputy superintendent of the New York department, summarized the results of a meeting several New York examiners attended. According to the memorandum, the examiners found Midland to be insolvent by more than $12 million as of December 31, 1975. However, instead of issuing the examination report as of that date, New York's examiners decided to extend the examination period to December 31, 1976. The examination period was extended for several reasons. One

reason was that Midland's financial vice president contended that certain developments occurred during 1976 that led to a huge improvement in Midland's finances, and so the vice president requested the New York examination period be extended to December 31, 1976. Further, a number of the larger examination adjustments reducing Midland's surplus were of a nonrecurring type that probably would not affect the insurer's reported surplus as of December 31, 1976. Moreover, it was agreed that even if new developments resulting in material adjustments caused a reduction in Midland's reported 1976 surplus of $18.1 million, the examiners had no information as of May 1977 to indicate Midland was insolvent as of December 31, 1976. Finally, the New York examiners believed that because of Midland's improved solvency position as reported in its 1976 annual statement, any regulatory action the department took on the basis of the 1975 examination would be defeated if challenged.

A California insurance examiner wrote to Midland's controller once in October 1977 and again in February 1978 requesting him to reconcile apparent inconsistencies between the amounts Midland reflected as ceded insurance in its 1976 annual statement and the amounts shown as business assumed from Midland by its reinsurers in their respective annual statements. Midland's senior vice president of finance finally responded to the department's request in late February 1978. He stated that the discrepancy shown between the amount of Midland's ceded reinsurance and the amounts shown on the assuming companies' statements was mainly caused by Midland's practice of showing the costs of its reinsurance at the maximum rates allowed by its reinsurance contracts while the company paid its reinsurers using the lower rates provided by those same reinsurance contracts. Further, adding to the discrepancy were timing differences caused by the differences between Midland's fiscal year and the fiscal years used by its reinsurers.

In June 1980, a department examiner completed his review of Midland's 1979 annual statement. Based on the examiner's calculations, Midland's reported surplus of $21.2 million was overstated by $24.2 million, resulting in the insurer being insolvent

by $3 million. According to the examiner's calculations, the two causes of this overstatement were reserve shortages and Midland's failure to withhold sufficient funds from reinsurers not licensed to do business in California.

In July 1980, one of the department's examiners wrote to the chief of the financial analysis division about the status of Midland. In his letter, the examiner noted the company was last examined as of December 31, 1976. As a result of that examination, the New York examiners had required Midland to substantially reduce its reported surplus. The examiner also stated that Midland was scheduled for another examination in 1980 and that he had recommended California participate in the examination. Finally, based on Midland's historic inability to establish adequate loss reserves, the examiner recommended Midland be placed on the department's internal watchlist as a company required to report on its financial condition each month. However, the department did not place Midland on its internal watchlist until January 1982, and then, only as a company required to send periodic reports or correspondence to the department.

In January 1981, one of the department's examiners summarized the results of the examination of Midland for the period ended December 31, 1976, conducted by the New York department. This examination originally covered the period ended December 31, 1975, but the New York examiners decided to extend the examination period to December 31, 1976. Four years later, the California department was finally made aware of the specific results. The New York examiners made numerous adjustments to Midland's account balances, resulting in almost a $10 million reduction of surplus to $8.3 million. The examiners criticized the way in which Midland recorded certain premiums it received as reinsurance when examiners discovered there was sufficient information to segregate the premiums by line of business. According to the examination summary, this practice of recording the premiums as reinsurance had the effect of vastly distorting Midland's analysis of losses and loss adjustment expenses used in establishing the reserves associated with the various lines of business Midland insured.

Apparently, some confusion existed within the department as to whether or not California was going to participate in the upcoming examination of Midland scheduled for the three years ended December 31, 1980, by the New York department. For example, both an examiner from the financial analysis division and its chief had sent requests to the chief of the field examination division during 1980 asking that California participate in the New York examination. In addition, in February 1981, the chief of the financial analysis division wrote a memorandum to the same examiner who originally requested California's participation in the examination stating that he had heard nothing from the field examination division concerning either of their earlier requests. However, apparently unknown to the financial analysis division, one of the department's examiners wrote to the chief of the field examination division in February 1981 to update him on the progress of the examination of Midland. In his letter, the examiner stated he had been participating in the examination since January 13, 1981, and estimated it would take six to nine months to complete.

In January 1982, the California examiner participating in the examination of Midland again updated the chief of the field examination division concerning the examination's progress. The examiner stated that the examination effort was centered on the analysis of the loss and loss adjustment expense reserves. The examiners were trying to segregate the types and classes of insurance business written by Midland within major lines and determine the effect that past reinsurance assumptions regarding former subsidiaries may have had in distorting loss reserve projections. Other than the loss reserve analysis, the examiner stated that the other parts of the examination were nearly complete and that the examiner-in-charge from New York had scheduled March 31, 1982, as the latest date for concluding fieldwork.

On May 5, 1985, more than three years after the scheduled end of its fieldwork, the New York department finally sent the results of its examination of Midland to the California department covering the period ended December 31, 1980. The examination report found Midland to be solvent, but examination adjustments reduced surplus by more than $16 million or almost 50 percent of the amount Midland originally reported.

Another indication the department had that Midland's financial condition was continuing to deteriorate came in April 1985. At that time, the department received a report of key financial ratios computed from Midland's 1984 annual statement by the NAIC. The results of that report showed Midland as having nine ratios outside the ranges considered normal for the industry. Midland's increased use of reinsurance caused one of those unusual ratios. The report noted that the amount of reinsurance Midland ceded had increased by more than $27 million from the amount reported in 1983.

In an internal memorandum written to his supervisor in May 1985, one of the department's examiners in the financial analysis division recommended taking regulatory action against Midland. His recommendation was prompted by Midland's financial performance as reported in its 1984 annual statement. Among other comments made in regard to Midland's performance, the examiner noted that Midland had reinsured business with three insurers that were in liquidation at the time, placing more than $2.6 million in jeopardy of collection. Furthermore, the examiner stated that Midland had entered into an additional $17 million worth of reinsurance with companies not authorized to transact business in California in 1984. Finally, based on his review of Midland's 1984 annual statement, the examiner believed that Midland's reported surplus was overstated by as much as $97 million, indicating that the insurer was insolvent by at least $74 million as of December 31, 1984.

In a memorandum written to the chief of the financial analysis division in June 1985, the financial analysis division supervisor who had received the May memorandum recommended the department issue a formal cease-and-desist order against Midland or require the insurer to voluntarily cease writing any new or renewal business in California. The department sent a letter on June 7, 1985, to Midland's president requesting the company to voluntarily cease writing any new or renewal business in California except for any renewal business contractually mandated by policies that Midland had already written.

During the next two months, the department considered a request from Midland's vice president to allow the company to continue to renew workers' compensation policies for maritime workers and to renew shortline railroad policies. In August 1985, the department agreed to allow Midland to renew the two lines of business requested in addition to renewing any in-force business that had a contractual provision mandating such renewal. However, the department restricted the volume of such renewal business in California to not exceed $9 million in direct premiums written during 1985 and $1.5 million during 1986. The department stated that it reserved the right to take formal regulatory action should Midland fail to comply with the department's restrictions.

In January 1986, the department again warned that it would take formal regulatory action against Midland. At that time, the chief of the financial analysis division wrote to Midland's vice president informing him that, since August 1985, the department had received an inordinate number of complaints about Midland's failure to refund unearned premiums to policyholders when Midland cancelled their policies. The department gave Midland a month in which to make a good faith effort to resolve these complaints or face a formal cease-and-desist order.

In early April 1986, the New York department notified the department that Midland had been placed into liquidation on April 3, 1986. A former insurance commissioner for California, in turn, conserved Midland in this state on April 15, 1986.

New York completed an examination of Midland in late December 1985 covering the four years ended December 31, 1984, that found the insurer to be insolvent by more than $24 million. Over half of the amount of the insolvency, more than $12 million, represented adjustments the examiners had Midland make to reflect the reduction to surplus caused by Midland's improper placement of reinsurance with companies under orders of rehabilitation or conservatorship.

While we were able to obtain the 1984 report of examination of Midland directly from New York, the report was never sent to California's department. Furthermore, we saw no evidence in either New York's or California's files to suggest that the New York Insurance Department kept California informed of Midland's financial condition during the course of the examination in which California did not participate.

Although the department had concerns about Midland's reinsurance arrangements as early as May 1974 that were serious enough that one of the department's examiners recommended that Midland's reinsurance program receive closer scrutiny, the department neither contacted the insurer nor increased its surveillance of Midland at that time.

Furthermore, in July 1980, one of the department's examiners recommended placing Midland on the department's watchlist as a company required to report monthly on its financial condition. However, this recommendation was not followed until January 1982, and even then, Midland was categorized as needing less regulatory oversight than was recommended.

In addition, New York noted problems with Midland's reinsurance during its examinations of the insurer for the years ended 1976 and 1980. In spite of these warnings, the department took no formal regulatory action until it conserved Midland in April 1986, after the New York examiners found the insurer to be insolvent by more than $24 million, half of which was caused by Midland's improper reinsurance.

Reserve Deficiencies

The department received yearly ratio analyses from the NAIC indicating that, from 1979 through 1985, Midland consistently had deficiencies in its reserves. In addition, the NAIC analysis of Midland's 1979 statements noted that Midland's reserving problems dated back to the late 1970s when its reserves were understated by approximately $17 million in 1977 and $6 million

in 1978. Moreover, the department's own reviews of Midland's annual statements for the years 1979 through 1985 also showed a consistent pattern of reserve deficiencies. In fact, after reviewing Midland's second quarter statement for 1984, an examiner recommended that a complete actuarial projection of Midland's reserves be made as of December 1984. The completed projection prepared by an actuarial consulting firm retained by Midland estimated that Midland had a reserve shortage of $17 million at the close of 1984.

The department also received information concerning Midland from New York. For example, the department learned that the New York examiners had reduced Midland's surplus by $9.8 million as a result of the 1976 field examination. Part of the reduction the New York examiners made to Midland's surplus was caused by an understatement in reserves of $15.7 million. A subsequent examination of Midland, also completed by New York in January 1983 and filed with the department in April 1985, found Midland's reserves to again be deficient by approximately $27 million as of December 31, 1980.

Finally, New York's examiners again examined Midland in May 1985 for the period ended December 31, 1984. This examination was completed in late December 1985 but was never sent to California by the New York regulator because Midland consented to liquidation. The New York examiners found Midland to have a deficit in its reserves of more than $33 million rendering Midland insolvent by more than $24 million. Midland was placed in liquidation by the superintendent of the New York Insurance Department on April 3, 1986.

Other than a reference to one meeting held with representatives of Midland and a letter sent to Midland's legal counsel in 1981, the California department had no documented direct contact with Midland concerning its reserve deficiencies until June 1985. At this time, the department directed Midland to voluntarily cease writing any new or renewal business in California except for contractually mandated renewal business. However, based on a subsequent meeting with representatives of Midland, the department modified

its position and allowed Midland to write a limited amount of renewal business. After receiving notification from New York of Midland's liquidation in April 1986, a former commissioner conserved Midland in California on April 15, 1986.

The department was aware Midland was having problems maintaining sufficient reserves as early as 1980. Further, the NAIC advised the department that Midland's reserving problems dated back to 1977. Despite the knowledge of Midland's chronic reserve deficiencies, the department took no formal regulatory action until more than six years later when the company was conserved in California. At that time Midland had reserve shortages of $33 million causing the company to be insolvent by $24 million.

Mission Insurance Company

Mission Insurance Company

State of Domicile: California
Net premium written in 1984: $244.4 million
Status: liquidated February 1987

Hazardous Conditions Exhibited		Year First Noted
Questionable investments	☐	
Improper reinsurance	☑	1985
Improper affiliate transactions	☐	
Reserve deficiencies	☑	1985
Poor underwriting	☐	
Poor use of managing general agents	☑	1985
Agents' high balances	☐	

The factors that contributed to the failure of the Mission Insurance Company (Mission) were improper reinsurance, reserve deficiencies, and poor use of managing general agents. It appears that, because of the way insurers reported information before Mission's insolvency, the California Department of Insurance (department) was not able to detect the problems that eventually caused Mission's failure early enough to prevent or minimize them.

The department placed Mission into conservatorship in October 1985 and declared it insolvent in November 1985. Before being appointed conservator of Mission by the court, the department approved Mission's attempt to rehabilitate itself through a non-cash infusion of $75 million into the Mission Group, Mission's parent company. A former commissioner conditionally approved the rehabilitation plan in May 1985 even though certain of the department's staff warned that the plan was not viable without an additional cash infusion. By October 1985, the

department determined that the rehabilitation plan was not working because of continued losses associated with the business Mission reinsured. Following is a detailed presentation of those factors leading to Mission's failure.

Improper Reinsurance

Mission's insolvency was caused partially by its inability to collect amounts owed from its reinsurers. Many of Mission's reinsurance arrangements were "pooled" with various reinsurers in the United States and overseas. A reinsurance pool is a joint underwriting of reinsurance in which the pool members assume a predetermined and fixed proportion of all the business assumed by the pool.

Before Mission's insolvency, the department did not receive the kind of information it needed to detect the fact that Mission's reinsurance would become the source of major problems in the future. Specifically, according to the chief of the financial analysis division, before 1988, insurers were not required to disclose how long amounts owed them by reinsurers had been outstanding or to identify reinsurers they dealt with that were located outside the United States. In 1983, the department's field examination division did note that the reinsurance pools managed by Pacific Reinsurance Management Corporation, a managing general agent and an affiliate of Mission, suffered losses between 1979 and 1982. Further, in early 1984, the NAIC's financial ratio analysis indicated that Mission had two ratios that fell outside industry norms. One of these ratios indicated that Mission might have large deposits with reinsurers.

However, while each of these incidents might have been an indicator of potential problems, they are neither clear nor obvious indicators of definite problems with reinsurance. Thus, the department was not able to detect Mission's problems with reinsurance. Moreover, the department was limited in its review of Mission because of the format in which reinsurance information was reported at the time.

According to a senior department examiner who participated in a special investigation of the company, Mission reported the amounts owed by its reinsurers without having the information necessary to determine how long the amounts due from reinsurers had been owed. Therefore, neither Mission nor the department had the means at that time to assess whether a particular reinsurer was likely to pay or not. Also, the department does not have regulatory authority over insurers located outside the United States and, therefore, cannot effectively evaluate the financial condition of these insurers. Since the insolvency of Mission, both the NAIC and the department now require insurers to disclose how long the amounts due from reinsurers have been owing on their annual statements and to disclose reinsurance placed with reinsurers located outside the United States. In addition, the chief of the financial analysis division stated that the department had also considered Mission to be a strong, stable insurer for a number of years and, therefore, the department monitored Mission as a non-priority company and did not monitor the company as closely as it did some other insurers. Because of limited staffing, the department concentrated its efforts on those insurers that showed clear signs of financial difficulty or potential financial difficulty.

According to the chief of the financial analysis division, Mission experienced large losses, in part, because of the types of risks it had insured. As these losses mounted, some of Mission's reinsurers dropped out of the reinsurance pools or simply refused to pay what they owed Mission, claiming that Mission had misled them about the risks they had reinsured. Some of the types of risks being underwritten by Mission at that time were workers' compensation, asbestosis, toxic shock syndrome, and various other chemical clean-up actions and environmental hazards. Further, some of the letters of credit or security deposits used to secure the reinsurers' performance were not large enough to adequately cover the costs of the claims. (A letter of credit is a security posted by a bank that ensures the payment of amounts due to an insurer if the reinsurer is unwilling or unable to pay.) As a result of its extensive reinsurance arrangements, Mission was heavily dependent on reinsurers to help pay for claimed losses. When those reinsurers either quit the pools, refused to pay, or were unable to pay their

share of claimed losses, Mission was left to pay for all the claims itself. This caused a severe drain on Mission's liquid assets until it could no longer pay the claims presented for payment. According to an examination of Mission as of December 31, 1984, completed in November 1985, Mission was unable to collect $40 million in reinsurance receivables from reinsurance pool participants. Furthermore, the department questioned whether Mission would be able to collect an additional $38 million owed from reinsurers that Mission dealt with. In November 1990, the special deputy insurance commissioner assigned to liquidate Mission and its affiliates noted that the dispute between Mission and some of its reinsurers was still being litigated in the courts. The special deputy insurance commissioner calculated that the nonpayment of amounts owed for reinsurance had grown to more than $1.4 billion.

Reserve Deficiencies

The department concluded that Mission's loss reserves as of December 31, 1984, were deficient by approximately $35 million and its loss adjustment expense reserves were deficient by approximately $19 million. A draft report of the financial analysis of Mission as of September 30, 1986 was prepared for the Texas Department of Insurance. The analysis indicated that Mission's reserves for losses were understated by approximately $149.5 million while its reserves for loss adjustment expenses also were understated by approximately $23.5 million.

Before March 1984, the department did not notice any problems with Mission's reserves. In October 1982, the department's actuary concluded that Mission had overestimated its combined loss and loss adjustment expense reserves as of December 31, 1981, by approximately $3 million and, therefore, its reserves were adequate. In March 1983, the NAIC's report of key financial ratios computed from Mission's 1982 annual statement did not show any of Mission's financial ratios to be outside the normal ranges for the industry.

However, in March 1984, the NAIC financial ratio report on Mission for 1983 indicated that Mission's ratio for two year overall operations and its ratio for liabilities to liquid assets were above the normal ranges. According to the NAIC handbook on ratio interpretation, the abnormal values of these two ratios could indicate that an insurer has suffered losses and reserve deficiencies. Further, the department's review of Mission's 1983 annual financial statement confirmed that Mission had an underwriting loss of approximately $38 million and an operating loss of approximately $15 million. The department's review of Mission's June 1984 quarterly statement also showed that the insurer suffered an additional $29.7 million underwriting loss and a $23.9 million loss in net income. Furthermore, Mission's surplus dropped by $50.7 million to $182.7 million, as of June 30, 1984.

In February 1985, the department scheduled a regular triennial examination of Mission to begin in March 1985 for the three years ended December 31, 1984. In advising the field examiners concerning what issues to be aware of during the impending examination, one of the department's examiners noted that Mission reportedly added $70 million to its loss reserves in the fourth quarter of 1984, indicating that Mission's reserves were deficient.

Subsequently, in March 1985, the parent company of Mission, Mission Insurance Group, informed the department that its board of directors had approved a plan for its principal shareholder to infuse $75 million in additional surplus for its subsidiaries. Of this proposed amount, $37.5 million would go to Mission and its subsidiaries. The proposed plan also called for a subsidiary of the principal shareholder to become the parent company of Mission and the lead company for the Mission Insurance Group. Further, the plan would have this subsidiary write most of the new and renewal business for the Mission group while Mission and its subsidiaries would primarily service existing policyholders until their respective policy terms lapsed.

Before requesting department staff to analyze the viability of the proposed plan, a former commissioner met with Mission's executives about the reorganization. The commissioner learned that the $75 million surplus infusion intended for the Mission Insurance Group was not to be a cash transaction. Instead, the infusion was to be a $37.5 million surplus increase for Mission by means of a loss portfolio transfer to a subsidiary of the principal shareholder outside of the Mission Insurance Group. Under the proposed plan, this subsidiary would assume up to $158 million of Mission's workers' compensation losses that occurred before April 1985 in exchange for $120.5 million in cash or marketable securities to be paid by Mission. The Mission Insurance Group would also inherit the $37.5 million net asset value of the subsidiary of the principal shareholder. The subsidiary would then become the parent company of Mission. According to an internal department document, Mission executives stated that the intent of the plan was to allow Mission to phase out its existing business in an orderly fashion with no harm to the policyholders. A former commissioner then directed his staff to determine the viability of Mission phasing out its existing business under the proposed plan.

The chief of the department's financial analysis division indicated he had serious reservations about the proposed plan. After analyzing the plan, the chief did not believe it was viable to phase out Mission's existing business under the proposed plan. The department staff who analyzed the proposed plan believed that an additional cash infusion was necessary at the inception of the plan. However, a former commissioner did not believe that requesting an additional cash infusion was feasible. The department subsequently approved the proposed plan with certain conditions in May 1985. As it turned out, the plan failed to save Mission because of its mounting losses and the refusal or inability of its reinsurers to meet their obligations. A former commissioner was eventually appointed by the court as conservator of Mission on October 31, 1985.

According to one of the department's examiners charged with the responsibility to investigate the Mission Insurance Group insolvency in July 1987, the department acted promptly when it

determined the Mission Insurance Group was in financial trouble. He further stated that the department immediately met with company managers and owners to determine the steps necessary to increase the surplus of the Mission companies. In the course of these discussions, the Mission group of companies received additional assets.

Further, according to the department examiner, the department did not receive information promptly for several reasons. The NAIC had standardized the quarterly and annual financial information Mission submitted to the department. At that time, the forms did not provide information that would have been useful to the department in analyzing the Mission Insurance Group. The vast majority of reserve deficiencies were associated with lines of business classified by Mission using the NAIC form under the single title "Other Liability." However, there were substantial differences in the loss development patterns of the various business lines contained under that one caption. To properly analyze whether an insurer has established adequate loss reserves, the category would have to be broken down into its component lines of business. The NAIC has since changed the statement format used to analyze losses to now require a breakdown by each of the principal lines of business an insurer writes. This change provides the department with a better analytical tool for use between examinations.

In February 1990, the Subcommittee on Oversight and Investigations of the Committee on Energy and Commerce of the United States House of Representatives issued a report entitled "Failed Promises: Insurance Company Insolvencies." The report states that fraudulent suppression of loss reserves was apparently rampant at Mission. It also states that adequate reserving was more critical for Mission than for other companies because of its policy of undercutting competitors' premium rates and generating loss ratios much higher than the industry average. The report notes that artificially low reserves were instrumental in improving the company's financial results reported to reinsurers and the public.

The report further states that the problems that caused Mission's insolvency were recognizable for several years before its collapse; however, the company's independent auditor, Coopers & Lybrand, did not detect or disclose its problems to policyholders, shareholders, reinsurers, regulators, or the public until 1984. Even then, Coopers & Lybrand qualified its audit opinion for unknown litigation contingencies, but not for any concerns regarding improper reserves or Mission's financial viability.

In addition, according to the report, it appears that the primary audit procedure used by Coopers & Lybrand to test losses was to have its actuary review Mission's actuarial computations. According to a 1984 memorandum by Coopers & Lybrand's actuary summarizing his review on Mission over the years, he reviewed only the understated recorded reserve figures, and there were significant differences between his estimates and those of Mission's management. In January 1983, he recommended that an independent appraiser be hired to resolve these differences; however this was not done. His concerns failed to result in any qualification of the Coopers & Lybrand audit opinion.

Poor Use of Managing General Agents

As discussed previously, faulty reinsurance arrangements significantly contributed to Mission's insolvency. According to a report issued by the Subcommittee on Oversight and Investigations of the Committee on Energy and Commerce, these reinsurance arrangements were developed by two wholly owned subsidiaries of Mission that acted as its managing general agents. During our review, we found that the department was not able to detect Mission's reinsurance arrangements developed through its managing general agents. For example, according to a department examiner who participated in a special investigation of Mission, the department's tools for detecting deficient reinsurance arrangements failed to reveal that Mission had inadequate control over the managing general agents that wrote reinsurance on Mission's behalf.

According to testimony before the United States House of Representatives' Committee on Energy and Commerce, Mission's managing general agents were committing Mission to various reinsurance pools with a variety of reinsurers operating outside the United States as early as 1980. However, as of 1981, the department's examination of Mission did not raise any issues about the broad powers of Mission's managing general agents to commit the company to reinsurance pools. Furthermore, although the department reviewed the managing agreements between Mission and its managing general agents in early 1983, it did not appear that the review included an evaluation of whether or not Mission was properly monitoring its managing general agents. It was not until the department's reinsurance examination as of December 31, 1984, completed in November 1985, that the department discussed the problems of Mission's managing general agents and reinsurance arrangements.

The department declared Mission to be insolvent by $99 million as of December 31, 1984, partly because of Mission's inability to collect the reinsurance owed and its extensive use of managing general agents that placed a significant amount of the reinsurance ultimately found to be uncollectible.

Since Mission's insolvency, the NAIC and the department have made improvements in the way insurers now must report information regarding reinsurance. For example, insurers must now disclose how long amounts owing from reinsurers have been outstanding. This helps the department to detect developing problems in the collectibility of reinsurance. In addition, on the financial statements they file with the department, insurers must now identify reinsurers located outside the United States or reinsurers not licensed in California. This type of disclosure allows the department to assess whether or not the insurer has withheld an appropriate amount of funds or letters of credit to ensure performance by these reinsurers. Finally, insurers must now report the amounts of reinsurance they have assumed and ceded and whether the reinsurance ceded was to an affiliate or non-affiliate.

Pacific Standard Life Insurance Company

Pacific Standard Life Insurance Company

State of Domicile: California
Net premium written in 1988: $108.3 million
Status: conserved December 1989

Hazardous Conditions Exhibited		Year First Noted
Questionable investments	☑	1977
Improper reinsurance	☐	
Improper affiliate transactions	☑	1983
Reserve deficiencies	☐	
Poor underwriting	☐	
Poor use of managing general agents	☐	
Agents' high balances	☐	

The factors that contributed to the failure of the Pacific Standard Life Insurance Company (Pacific Standard) were questionable investments and improper affiliate transactions. While the California Department of Insurance (department) was able to detect these hazardous conditions well before Pacific Standard's failure, it did not ensure the company took prompt and effective action to correct them. Following is a detailed presentation of those factors contributing to Pacific Standard's failure.

Questionable Investments

The former commissioner was appointed by the court as conservator of Pacific Standard in December 1989. The department had been concerned about Pacific Standard's investments in real estate as early as 1977. Pacific Standard was, at that time, domiciled in Arizona. According to an internal

department memorandum, Arizona and California participated in an examination of the company as of December 31, 1976, that found that Pacific Standard's investment in two parcels of real estate located in Hawaii were in excess of the investment limitations of both Arizona and California law. According to the California Insurance Code, this limitation requires that the aggregate holdings in real estate not exceed 10 percent of the insurer's admitted assets. According to a task force study done on insurer insolvency, heavy concentrations in high-risk investments by an insurer can affect its solvency. Investments in commercial real estate are generally acknowledged to be more risky than investments in securities such as government-backed bonds.

Subsequently, Arizona's insurance director allowed Pacific Standard to reflect these parcels as admitted assets as long as the company agreed to dispose of them by June 30, 1979. Another examination of Pacific Standard as of June 30, 1979, found that, while the company still held one of the two Hawaiian parcels, the gross value of the parcel no longer exceeded the aggregate investment limitations of Arizona or California. However, the report indicated that Pacific Standard's investment in the one remaining parcel still exceeded California's investment limitation concerning single parcels of real estate. This limitation holds that investments in a single parcel of real estate not exceed one percent of the insurer's admitted assets or 10 percent of the aggregate of the insurer's capital and unassigned surplus, whichever is larger.

Between 1979 and 1982, the department repeatedly questioned Pacific Standard regarding its real estate investments. Further, in a 1983 letter written to a department examiner summarizing past problems with Pacific Standard, another examiner expressed the belief that to circumvent California's investment limitations, the company transferred title to real estate acquired from an affiliate to other parties in exchange for mortgage loans. These mortgage loans were not subject to the real estate investment limitations and were, therefore, admitted assets according to California law. However, many of these mortgage loans had provided no income to Pacific Standard in the form of interest payments or reductions in principal, indicating that these assets were nonperforming and might be in default.

In August 1983, Southmark Corporation (Southmark), a real estate-based financial services company, acquired Pacific Standard. In 1985, through a financial analysis of Pacific Standard's 1984 annual statements, a department examiner found the insurer was continuing its questionable real estate investment activities and that Southmark was now contributing many of the mortgage loans. Furthermore, examiners from Arizona and California completed an examination of the company in August 1986 for the three years ended December 31, 1985. The examiners found that the mortgage loans Southmark contributed during 1983 and 1984 either had been assigned but not recorded in Pacific Standard's name or had not even been assigned to the company. These loans, totaling more than $20 million, were initially disallowed as reportable assets by the examiners, rendering the company statutorily insolvent. Only after California threatened to issue a cease-and-desist order in January 1987 did Pacific Standard take the steps necessary to correct the inadequate documentation supporting the mortgage loans. As part of the corrective action, Pacific Standard returned almost $7 million of the mortgage loans to Southmark because the loans either were not providing any income or were in foreclosure. The examination report also noted that California examiners still considered the company to be in violation of California's real estate investment limitations regarding investment in a single parcel. Finally, the report disclosed that Pacific Standard's financial committee was comprised of only one person, the chairman and president of Southmark, Pacific Standard's parent.

In June 1986, Pacific Standard applied to the department for an organization permit as a first step in redomesticating in California. To accomplish the redomestication, Pacific Standard wanted to create a subsidiary, Pacific Standard of California, and merge the Arizona company into the California company. The examiner reviewing the proposed redomestication transaction concluded that redomesticating in California would improve the department's control over the company. The merger of these two companies was approved and became effective January 1, 1989.

Between July 1987 and November 1989, the department was increasingly concerned about Pacific Standard's large investments in real estate and stocks and that many of the company's investments were with affiliates or Southmark, its parent. Specifically, a department examiner found in her review of the March 1988 financial statements filed by Pacific Standard that approximately 69 percent of Pacific Standard's invested assets were illiquid. In other words, Pacific Standard would not be able to readily convert these assets into cash. It is important for an insurer to have a ready source of cash to promptly pay the claims filed by its policyholders. The examiner also noted that Pacific Standard's junk bonds comprised 7.1 percent of its invested assets and that a substantial portion of its assets had a very low investment yield. The department's examiner also found that almost $23 million worth of the stocks that Pacific Standard had received from its parent company were shown in the company's financial statements at values that might have been inappropriate and unreasonable as they were privately traded and had no ready market value and had not been submitted to the Securities Valuation Office (SVO) for valuation. Insurers' investments in actively traded stocks have a ready market and share prices are quoted daily. Insurers' investments in privately traded stocks must be valued by the SVO. Examiners use these two independent sources to determine whether the insurer has recorded its stock investments at appropriate values. The examiner concluded that Pacific Standard was acting like a bank for its affiliates by providing them cash in exchange for assets of questionable value and that most of the transactions were not the investment transactions usually found in the ordinary course of an insurer's business. Furthermore, the examiner recommended that Pacific Standard undergo a special examination focusing on the admissibility of the company's mortgage loans and other investments. However, the department did not schedule an examination of Pacific Standard until one year later, in May 1989.

In February 1989, the department's financial analysis division noticed that Pacific Standard's policyholders' surplus had fallen from $44.8 million as of December 31, 1987, to $21.1 million as of September 30, 1988, more than a 50 percent drop in nine months. This decrease was caused by net losses from operations

and capital losses. The capital losses were largely due to decreases in the market value of the company's investments in subsidiary and affiliate common stocks. In addition, by September 30, 1988, approximately 39 percent of Pacific Standard's assets were invested in mortgage loans, real estate, and other real estate related investments. The analysis by the financial analysis division noted that high concentrations of investments in one type of business was risky and that Pacific Standard has had problems in the past with real estate. Further, Pacific Standard had invested $13 million in the preferred stocks of a company whose stocks may have been restricted and worthless at the time of the investment. Moreover, the analysis showed that Pacific Standard's common stock investment was composed mainly of other affiliates' stocks. In addition, a substantial portion of Pacific Standard's bonds was made up of junk bonds, and investment services characterize these types of bonds to be generally lacking the characteristics of desirable investments with little assurance that principal and interest payments will be made over the long term. The examiner who performed the analysis concluded that Pacific Standard's overall investment picture was not good, especially in terms of liquidity.

In March 1989, an examiner from the financial analysis division again recommended a field examination as soon as possible because Pacific Standard's parent company and affiliates had transferred approximately $100 million worth of illiquid assets such as real estate, mortgage loans, and other real estate related investments in exchange for cash and securities. Two months later, an examiner from the financial analysis division advised another examiner who was conducting the field examination of Pacific Standard at the time that Southmark may have intentionally dumped overvalued assets into the company. In addition, the examiner from the financial analysis division suspected that, because Southmark was experiencing financial difficulties and was desperate for cash, it exchanged overvalued assets for the good assets of Pacific Standard without first obtaining approval from the commissioner, as the law requires for such large transactions among affiliates. Further, the examiner from the financial analysis division indicated to the field examiner that she had previously

written to Pacific Standard on two occasions during 1987 concerning the department's requirements regarding transactions among affiliates. However, the company did not respond until June 1988, and in the meantime, Pacific Standard completed several more affiliated transactions without seeking prior approval from the department.

In spite of its long-standing concerns, the department relied on informal actions as the means to correct Pacific Standard's questionable investments in real estate and stocks. However, these informal actions failed to effectively control Pacific Standard's investments in these two areas. Through its field examination filed in February 1990 for the three years ended January 1, 1989, the department found that Pacific Standard had overvalued its investments in real estate, mortgage loans, collateral loans, and stocks by more than $79 million. Moreover, the department did not adjust the bond portfolio to reflect the market values of Pacific Standard's holdings of high-yield junk bonds. However, the report stated that more than 60 percent of the company's bond portfolio, valued at $185 million on January 1, 1989, was invested in bonds rated "B" or below by Moody's Investment Services. Moody's defines a "B" bond rating as bonds generally lacking the characteristics of desirable investments with little assurance that principal and interest payments will be made over the long term.

The department recognized and knew of the questionable nature of Pacific Standard's investments, yet it did not ensure that the company took prompt corrective actions designed to correct the problems. The department found that Pacific Standard was involved in questionable real estate investments as early as 1977. In the years following 1983, Pacific Standard's parent company and affiliates dumped overvalued real estate, mortgage loans, stocks, and other investments into Pacific Standard in exchange for cash and liquid assets. The fact that the only member of Pacific Standard's finance committee was also the chairman and president of Pacific Standard's parent company also helped to facilitate the transaction of these questionable investments. In fact, the department is currently pursuing a lawsuit against the former officers and directors of Pacific Standard alleging breach of fiduciary duties, conspiracy, and looting and waste of corporate assets in excess of $12 million.

Improper Affiliate Transactions

The department had concerns about Pacific Standard's improper affiliate transactions as early as 1983. Specifically, in a 1983 letter written to a department examiner summarizing past problems with Pacific Standard, another examiner expressed the belief that to circumvent California's investment limitations, the company transferred title to real estate acquired from one affiliate to other affiliates, partnerships, and joint ventures in exchange for mortgage loans. These mortgage loans were not subject to the real estate investment limitations found in California law and were, therefore, allowable as admitted assets. However, many of these mortgage loans provided no income to Pacific Standard in the form of interest payments or reductions in principal, indicating that these assets were nonperforming and might have been in default.

In 1985, the department again noted concerns regarding Pacific Standard's affiliate transactions. A department examiner recommended denying a request from Pacific Standard for the company to be exempted from the reporting requirements under the California Holding Company Act. Among her reasons, the examiner cited that, during 1983 and 1984, Pacific Standard completed 20 affiliate transactions totaling more than $65 million, many of which appeared questionable. For example, Pacific Standard paid out dividends in the same year it borrowed a significant amount from an affiliate although, to the examiner, such a transaction did not make good business sense. Specifically, Pacific Standard paid a $1.3 million dividend the same year it borrowed $8.4 million from an affiliate. The department agreed with the examiner and denied Pacific Standard's request.

The department again addressed the issue of affiliate transactions in a letter to Pacific Standard in January 1987. In that letter, the chief of the financial analysis division informed the company it had entered into affiliate transactions requiring the prior approval of the commissioner, and it had failed to obtain such approval in violation of the California Insurance Code. Pacific Standard responded to the department's letter stating that its legal counsel was reviewing the appropriate code section regarding the need for prior approval of affiliate transactions to determine if the company had failed to comply with California law.

Although a department examiner indicated in February 1987 that she would wait awhile and then follow up on Pacific Standard's violations of the California Holding Company Act, we found that the department did not make any more inquiries until November 1987. At that time, the department again wrote to Pacific Standard and reiterated the requirements regarding affiliate transactions and requested information regarding any such transactions that may have taken place after December 1986. More than seven months later, in June 1988, Pacific Standard finally responded, stating that the company was aware of the requirements relating to affiliate transactions and that it was complying with the law. However, after receiving one of Pacific Standard's filings completed between September 1987 and February 1988 disclosing affiliate transactions, one of the department's legal counsels expressed concern that, although most of the transactions required reporting or prior approval, Pacific Standard either did not report the transactions or failed to seek the department's prior approval. Furthermore, the legal counsel stated in an internal memorandum that the department's lack of action regarding Pacific Standard's affiliate transactions may have encouraged the company to act as if there were no regulatory requirements. Finally, the counsel requested that the financial analysis division review the filing and determine if regulatory action should be taken.

After reviewing Pacific Standard's filing of affiliate transactions in August 1988, an examiner from the financial analysis division concluded that all the company's affiliate transactions since January 1987 were willful violations of the law. Further, the examiner concluded that such actions threatened the financial condition of Pacific Standard and posed a hazard to its policyholders. It appeared to the examiner that Pacific Standard was acting like a bank for its affiliates because many of the transactions were for the purpose of transferring cash from Pacific Standard to its affiliates in exchange for illiquid assets such as mortgage loans. In addition, the examiner noted that most of the affiliate transactions appeared to be mere accommodations to affiliates and not the usual investment transactions found in the ordinary course of business.

Furthermore, the examiner stated that, as of December 31, 1987, Pacific Standard had investments in affiliates amounting to more than $95 million but had reported less than half that amount in its annual statements. Also, Pacific Standard had made additional investments in affiliates in early 1988 totaling almost $22 million that, when added to the 1987 balance in affiliate transactions, was more than three times the amount of the policyholders' surplus reported for 1987. Finally, the examiner recommended that the department take regulatory action against Pacific Standard for violating the law and also recommended initiating a special examination to determine whether Pacific Standard's various investments in affiliates were admissable as assets. The department's legal counsel, after reviewing the examiner's conclusions, also recommended that Pacific Standard be examined. However, the counsel deferred to the chief of the financial analysis division what, if any, action to take.

Despite these reviews and recommendations, the department did not take any regulatory action or schedule Pacific Standard for a field examination until May 1989, more than nine months later. In the interim, a department examiner reviewed Pacific Standard's quarterly statement as of September 1988 and noted that the company had increased its affiliate transactions. Specifically, the examiner found that, between February 1, 1988, and September 30, 1988, Pacific Standard had acquired more than $97 million in assets from its affiliates. The bulk of these transactions were purchases by Pacific Standard from Southmark Corporation, its parent company, and other affiliates. The purchases were of nonliquid real estate related assets such as mortgage loans, real estate, real estate partnership interests, and loans to affiliates collateralized by vacation time-share contracts. These transactions had the effect of removing cash from Pacific Standard and transferring it to Southmark and other affiliates. The department examiner concluded that Southmark was desperately in need of Pacific Standard's liquid assets because the parent company was suffering from severe cash flow problems and other financial crises.

The department filed its field examination of Pacific Standard in February 1990 covering the three years ended January 1, 1989. The results of the examination confirmed that Pacific Standard had acquired many overvalued and worthless assets from its affiliates. Examples of these assets included: mortgage loans already in default; mortgage loans secured with second, third, or even fourth liens; nonperforming collateral loans; investments in the preferred stocks of the parent company, which had filed bankruptcy; and illiquid investments in stocks and partnerships not publicly traded and, therefore, with no ready market. Ultimately, department examiners found more than $79 million in overvalued real estate and stocks. The majority of these assets were the result of improper transactions between Pacific Standard and its affiliates.

The department is currently pursuing a civil lawsuit against the former officers and directors of Pacific Standard alleging breach of fiduciary duty, conspiracy, and the looting and waste of corporate assets. The department is seeking damages in excess of $12 million.

The department had concerns about Pacific Standard's affiliate transactions as early as 1983. In subsequent years, the department failed to take any regulatory action despite the fact that Pacific Standard repeatedly and willfully violated the California Holding Company Act with its affiliate transactions. Seven years later, in 1990, the department's examiners declared Pacific Standard insolvent mainly because of its acquisition of more than $79 million worth of overvalued and worthless assets, the majority of which were acquired from affiliates.

Transit Casualty Insurance Company

Transit Casualty Insurance Company

State of Domicile: Missouri
Net premium written in 1984: $60.5 million
Status: liquidated January 1986

Hazardous Conditions Exhibited		Year First Noted
Questionable investments	☐	
Improper reinsurance	☑	1982
Improper affiliate transactions	☐	
Reserve deficiencies	☑	1984
Poor underwriting	☑	1984
Poor use of managing general agents	☑	1982
Agents' high balances	☐	

A former commissioner of the California Department of Insurance (department) conserved Transit Casualty Company (Transit) in December 1985. Transit was a Missouri domiciled company headquartered in Los Angeles and licensed to conduct insurance business in California. Because of the lack of documentation concerning this insurer in both the files maintained by the California department and the Missouri Division of Insurance, we are not able to independently substantiate the causes that contributed to the insolvency of Transit. However, according to available documents and reports, it appears that Transit's poor use of managing general agents to expand its business during the early 1980s and its subsequent failure to adequately monitor those agents and their subagents created reinsurance, underwriting, and reserving problems at Transit that eventually led to its failure. Furthermore, based on available information, the department received ample warning concerning the practices that caused Transit's insolvency. Following is a detailed presentation of those factors leading to Transit's failure.

Poor Use of Managing General Agents

In February 1990, the Subcommittee on Oversight and Investigations of the Committee on Energy and Commerce of the United States House of Representatives released its report entitled "Failed Promises: Insurance Company Insolvencies". According to testimony obtained by the subcommittee, Transit made a decision in 1979 to expand its operations by offering coverage for property and casualty risks that were unrelated to its traditional areas of experience. Up to that point, Transit had been underwriting property and casualty risks associated with only commercial transportation. Transit used managing general agents to expand into these new insurance markets. A managing general agent is an individual who manages all or part of the insurance business for an insurer, underwrites premiums, and adjusts or pays claims. Transit's management believed any resulting underwriting risk was minimal because the insurer would mainly serve as a front to write business in return for a fee paid by the managing general agents, who would then reinsure the business with other companies.

Between 1980 and 1985, Transit used 17 managing general agents and approximately 1,000 subagents to write high-risk coverage in such areas as fire, marine, medical malpractice, toxic waste sites, automobile liability and property, aircrafts, surety, liquor liability, taxi drivers, race horses, and assumed reinsurance. This business was then reinsured by the managing general agents with approximately 1,200 to 1,400 other companies, which were primarily located offshore and not authorized to do business in the United States. Transit's receiver testified that, as a result of Transit's expansion plans, the insurer's direct premiums soared from $93 million in 1979 to $227 million at the end of 1984 while assumed premiums from the business Transit reinsured grew tenfold from $5 million to $51 million. Furthermore, the premiums Transit paid to its reinsurers also rose dramatically during the same period from $23 million to $217 million.

The report further stated that Transit's managing general agents were not given any underwriting guidelines and their activities were not monitored by the insurer. Because there was a six-to-

eight-month time lag before the managing general agents reported their premiums, Transit could only wait to see where it stood financially. When the reports from the managing general agents finally arrived, the insurer had no adequate computer system to process them.

By the end of 1983, Transit's reinsurance operation was out of control. According to the report, the managing general agents signed up subagents and reinsurers without first obtaining approval from Transit that they were soundly managed or adequately capitalized. Further, Transit had no master list to record all the blank policies that were furnished to the managing general agents and could not determine how many policies had been written, so there was no way to reconcile the premiums collected to individual policies. Therefore, the information Transit used to develop its financial statements was incomplete, inaccurate, and outdated. The receiver for Transit testified that, at least by the end of 1984, the insurer was insolvent and that its financial statements were materially misstated for two or three years before that.

During our review of the department's files, we could find nothing to indicate that the department had performed any type of detailed analysis of Transit's 1981 or 1982 annual statements. However, in July 1981, the Missouri Division of Insurance began an examination of Transit covering the three years ended December 31, 1980. This was a multistate examination with examiners also participating from the states of Kentucky and Nevada. The multistate examination, called an association examination, was completed in March and the report was received by the California Department of Insurance in May 1982. While not going into detail concerning Transit's expansion into other lines of insurance coverage, the examiners did note that business was produced through the use of approximately 500 independent agents and 160 brokers, assisted by Transit's own marketing personnel. Furthermore, the examiners explained that these independent agents and brokers earned commissions based on the volume of premiums they wrote, according to contractual arrangements. Additionally, selected agents could earn profit-sharing commissions based on premium volume and loss experience. Also,

the report mentioned that, although Transit had been a transportation specialist, through its newly established risk management department, it would begin writing other coverages such as liability and specialized package programs and would accept property and casualty risks written by other insurers in the form of assumed reinsurance.

The examiners made adjustments to increase Transit's 1980 year-end surplus by approximately $400,000. However, they noted several areas that should have been of concern to California, the state in which Transit wrote the most business. For instance, the examiners criticized Transit's recordkeeping. Critical data supporting accounts in the annual statement and needed for review during the examination were unavailable because of missing computer runs, scratched back-up computer tapes, and inadequate workpapers. In these cases, the examiners had to rely on less desirable alternate means to substantiate the account balances the insurer reported.

Further, the examiners commented that Transit's computerized set of accounts was not useful in reconciling the various account balances with the items in Transit's annual financial statement. The reason given was that the computerized set of accounts showed the account totals only, without including the detail making up each account total. In addition, for the liability account entitled "unearned premiums," the examiners noted that of the $3.6 million in unearned premiums ceded to reinsurers, $3.2 million was ceded to reinsurers not authorized to transact insurance business in the states in which Transit was licensed. (At the expiration of an insurance policy or contract, the entire premium has been earned. At any point before expiration, the insurer is required to establish a pro rata portion of the premium as a liability to cover the remaining policy or contract term. The account used for this purpose is entitled "unearned premiums".) The examiners did state that Transit held letters of credit equal to the amount ceded to unauthorized reinsurers. However, it was not clear whether the examiners reviewed the letters of credit to be satisfied as to their form.

In April 1984, the National Association of Insurance Commissioners (NAIC) released its analysis of key financial ratios based on Transit's 1983 annual statement. The analysis showed that Transit had three ratios considered unusual compared with industry averages. The largest variance among the three unusual ratios was the ratio of agents' balance to surplus. According to the NAIC's analysis, Transit's agents' balance represented 131 percent of its surplus at December 31, 1983. The upper end of the industry average range for this ratio is 40 percent of surplus. However, there was no evidence in the department's files indicating the department followed up on the issue of the excessive agents' balance with Transit.

In the course of conducting an audit of the reinsurance shown in the 1983 annual statements of insurers licensed in California, a department examiner sent a letter to Transit in June 1984. The examiner stated that, according to Transit's annual statement for 1983, the company was very heavily insured with unauthorized reinsurers. The examiner noted that the amount recoverable from these unauthorized reinsurers for paid and unpaid losses and unearned premiums relating to the business Transit reinsured totaled more than $70 million. Because the amount reinsured with these reinsurers far exceeded Transit's surplus at the end of 1983, the examiner requested that Transit send copies of certain large letters of credit received from nine of its unauthorized reinsurers located in Bermuda and the Grand Cayman Islands so that the department could study them.

Also in June 1984, the same examiner who sent the letter to Transit also wrote an internal memorandum concerning Transit's use of reinsurance. In his memorandum, the examiner summarized his concerns regarding Transit's heavy reliance on reinsurance with unauthorized reinsurers. While he believed that most of the reinsurers involved would not pose any problems because the funds withheld and letters of credit in Transit's possession were adequate, he stated that reinsurers located in Bermuda and the Grand Cayman Islands merited further review. Therefore, he had requested that Transit send the department copies of any letters of credit involving these nine reinsurers. Furthermore, the examiner stated that

another letter would be sent to Transit requesting that the agreements between it and the seven managing general agents having the authority to assume and cede reinsurance on Transit's behalf be sent to the department. During our review of the department's files on Transit, we did not find any indication that the insurer ever responded to the department's requests for information about its letters of credit from unauthorized reinsurers or about its agreements with its managing general agents.

The department completed a comparative analysis of Transit's financial statements for calendar years 1983 and 1984. We were unable to determine when this analysis occurred, however, because the examiner who performed the review did not date it. Nevertheless, the examiner's analysis of Transit's 1984 annual financial statement revealed that the insurer's surplus had fallen to approximately $22 million, a drop of more than 50 percent from the approximately $44 million in surplus reported by Transit as of December 31, 1983. Furthermore, the examiner noted that the department's actuary believed that Transit's reserves for losses were understated by a large amount.

In an article written in January 1985, the insurance analyst, A.M. Best, stated that Transit had decided to cease all underwriting activities other than transportation risks because of continuing losses. The article further stated that Transit had curtailed its underwriting because it had expanded too rapidly and at inadequate rate levels into insurance programs other than transportation. The article stated that, as a result, Transit had posted an underwriting loss during the first nine months of 1984 of approximately $18 million.

In April 1985, the actuary for the California Department of Insurance sent a memorandum to the California examiners participating in the ongoing examination of Transit. The actuary advised the examiners to state in their report that Transit's reserves for losses and loss adjustment expenses were understated by approximately $11 million at December 31, 1983. Furthermore, the actuary stated that, because of the volume of business that Transit reinsured, it was not possible to estimate whether or not

further reserve shortages would develop. Finally, the actuary stated that, based on his review of Transit's 1984 annual statement, the true financial condition of the insurer was uncertain because it depended so much on Transit's ability to collect on reinsured losses.

In April 1985, the Missouri Division of Insurance, with examiners representing California, Georgia, and Delaware, completed an association examination of Transit. This examination began in September 1984 and covered the three years ended December 31, 1983. The examiners made adjustments to Transit's reported account balances for 1983 that ultimately reduced the company's reported surplus from approximately $44 million to $23 million, a drop of almost 50 percent. The three areas most affected by the examiners' adjustments were Transit's reserves for losses, liability for unauthorized reinsurance, and agents' balance. Specifically, the examiners required Transit to increase its loss and expense reserves by almost $11 million based on an actuarial study and to increase another liability account by more than $5 million to recognize an amount that might prove uncollectible from Transit's reinsurers. The examiners also required Transit to reduce its agents' balance, an asset, by more than $5 million because Transit had included balances due from two of its managing general agents that had owed the amounts for more than 90 days. To be reported as an asset, the annual statement form insurers file requires that agents' balance be reported net of amounts owing more than 90 days.

Further, in their comments concerning agreements for managing general agents, the examiners stated that, during 1981, Transit appointed a number of agents. These agents would write business in Transit's name and then reinsure almost 100 percent of this business with reinsurers owned by associations or subagents of the managing general agents. This fronting practice resulted in Transit receiving a small fronting fee from its managing general agents. The volume of business generated by Transit's managing general agents through these fronting arrangements grew so much that, for 1983 alone, the amount of Transit's direct business in addition to the business the company assumed through reinsurance

approximated $238 million. Of this amount, the managing general agents ceded $197 million to other reinsurers so that the net amount of written premium Transit reported was approximately $41 million.

The examiners reviewed Transit's agreements with managing general agents and concluded that the agents' actions were not generally in agreement with their contractual arrangements with Transit. Specifically, the examiners faulted the managing general agents for such actions as not remitting premiums to Transit promptly, not promptly providing Transit with acceptable letters of credit for unauthorized reinsurers, not setting up trust accounts for premiums collected on Transit's behalf, and not providing Transit with sufficient detail regarding managing general agent operations. Furthermore, the examiners criticized Transit for its failure to exercise adequate control over the actions of its managing general agents during the period under examination.

The examiners illustrated Transit's failure to exert proper control over the company's managing general agents using one agent as an example. The examiners stated that this agent, Donald F. Muldoon & Company (Muldoon), was given the same kind of broad authority by Transit as some of its other managing general agents to underwrite risks in Transit's name and appoint subagents responsible for reinsuring the business written with reinsurers under the control of these subagents. However, rather than obtaining approval from Transit before appointing subagents or entering into binding reinsurance agreements, as was required by Muldoon's and other agents' agreements, these actions were often taken without Transit's approval.

Moreover, because of the tremendous increase in premium volume generated by the managing general agents, Transit's accounting and data processing units were overwhelmed and unable to process the increase in business. According to the examiners, although a division was set up within Transit in 1981 to supervise the actions of its managing general agents, the increase in business volume resulted in a lack of coordination between this division and Transit's accounting unit. For example, Transit did not establish a

method to segregate its agents' balance for amounts owing more than 90 days, did not institute controls over the issuance of policies, and did not ensure that the letters of credit its managing general agents obtained for business they reinsured were adequate. Without such controls in place, Transit could not verify the amount of premiums written, the amount of premiums ceded to reinsurers, or the amount representing unearned premiums. Moreover, it could not verify the amount it should reduce its loss reserves by to reflect risks reinsured on Transit's behalf by one of its managing general agents.

Finally, the examiners noted that, during 1983, Transit's internal auditor began a program for conducting periodic audits of various managing general agents, along with audits of their subagents. As a result of these internal audits, almost all agreements with managing general agents were terminated during 1983 and 1984. Moreover, Transit called for an independent audit of one of Muldoon's subagents that resulted in Transit filing suit against this subagent in December 1984 for breach of fiduciary responsibility, breach of contract, and failure to report and remit premiums due to Transit.

Between April and October 1985, the department received various indications of Transit's continuing financial deterioration. In April, the department received the NAIC's analysis of key financial ratios based on Transit's 1984 annual statement. For 8 of the 11 ratios the NAIC computed, Transit had values that were unusual compared with industry averages. Then, in May, Transit's president informed the department that, because of inadequate records, Transit was experiencing difficulties in determining the amount of losses originating from business produced by one of its managing general agents. The president further stated that Transit would voluntarily discontinue writing all new and renewal business of any kind, and management would focus its attention on collecting approximately $45 million of recoverable reinsurance from the agent to maintain Transit's solvency. Finally, in October, after reviewing Transit's quarterly statement as of June 30, 1985, one of the department's examiners reported to his supervisor that Transit's surplus had declined from the $22 million reported in

December 1984 to just $3.3 million, an 85 percent reduction in six months. Further, Transit reported an agents' balance of $62 million, or 19 times the amount of its surplus and also reported net losses of $19 million. The examiner concluded that Missouri, the state of domicile, should take action to conserve Transit and asked what California could do. It appears that the examiner's supervisor responded stating that, beyond the department's obtaining a voluntary agreement by Transit not to write any new or renewal business in California without the department's approval, there was not much else the department could do.

Finally, on December 3, 1985, the Missouri Division of Insurance placed Transit into conservation, and the next day, a former California insurance commissioner placed Transit into conservation in this state.

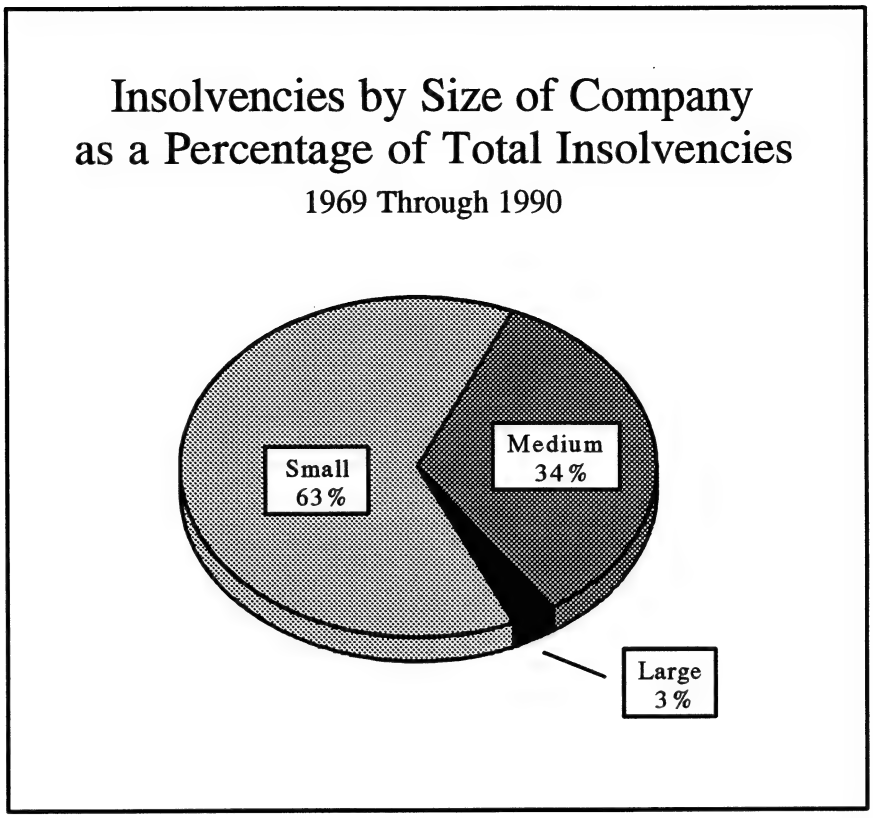
Although the department did not appear to monitor Transit to the degree it monitored the other companies we reviewed, it still received ample warning concerning the factors that eventually caused Transit to fail. For example, in May 1982, California received an association examination report on Transit that described the insurer's extensive use of managing general agents. The same examination commented on Transit's poor recordkeeping practices as well as the fact that it was branching out into new lines of business. Finally, this examination noted that Transit was beginning to reinsure with companies not licensed to conduct business in the states where Transit did business. In April 1984, the department also received from the NAIC advanced warning concerning the volume of business placed by Transit's managing general agents. The NAIC's analysis of key financial ratios computed from Transit's 1983 annual statement found that Transit's agents' balance equaled 131 percent of its reported surplus as of December 31, 1983. However, we found no indication that the department heeded these warnings by increasing its monitoring efforts regarding Transit until it was conserved by its domicile state in December 1985.

Appendix B Trends in Property and Casualty Insolvencies

A.M. Best, an agency that rates insurance companies, conducted a nationwide study of all property and casualty insolvencies occurring since 1969. In its study, A.M. Best found several trends in the nature of these property and casualty insolvencies. The trends involved various characteristics of property and casualty insurers such as size, age, growth in volume of premiums, and nature of insurance lines written.

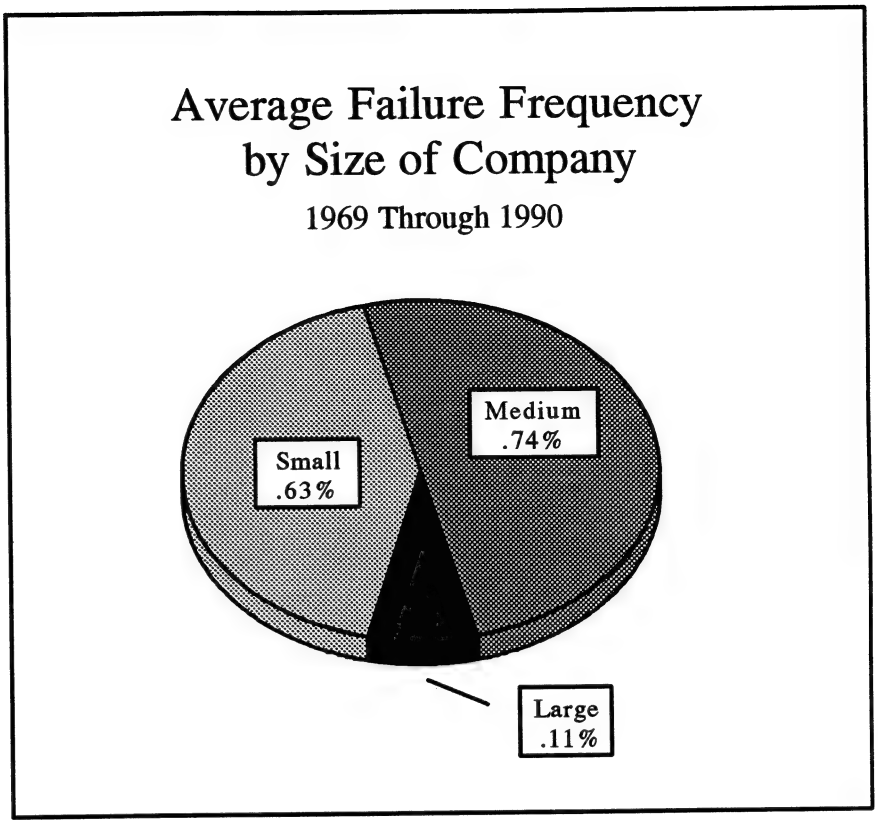
The first trend A.M. Best identified involved the size of the insurer. According to A.M. Best, small-sized companies accounted for 63 percent of the insolvencies nationwide between 1969 and 1990, medium-sized companies accounted for 34 percent, and large-sized companies accounted for 3 percent. In 1990, A.M. Best defined small-sized companies as companies with policyholders' surpluses of $5 million or less, medium-sized companies as companies with policyholders' surpluses of $5 million to $50 million, and large-sized companies as companies with policyholders' surpluses of $50 million or more. Since 1969, A.M. Best has adjusted the policyholders' surplus for each insolvent company in the study by a 10 percent growth factor each year. The policyholders' surplus is defined as the sum remaining after all liabilities are deducted from assets. Essentially, policyholders' surplus represents an insurer's statutory net worth. Figure B-1 illustrates the number of insolvencies presented by company size expressed as a percentage of total insolvencies.

Figure B-1



When the number of insolvencies by size of company nationwide are compared with the number of companies nationwide within the respective size segments, medium-sized companies have the highest average failure rate. Thus, although the smallest-sized companies accounted for the greatest number of insolvencies nationwide, they experienced a lower average failure rate than the medium-sized companies, with the largest-sized companies experiencing the lowest failure rate. The following figure illustrates average failure frequency nationwide by size of company. Of the 14 insolvent insurers we examined, 10 were property and casualty insurers. Of those 10, three were small, six were medium, and one was large using A.M. Best's measurements of size.

Figure B-2



The second trend A.M. Best identified involved the number of years insurers were in business before their insolvencies. Young or unseasoned companies accounted for half of the insolvencies. Companies having 15 years or less business experience were considered to be young or unseasoned. However, this group represented only 27 percent of all companies in the industry. Of our sample of 10 insolvent property and casualty insurers, four (40 percent) had been in business less than 15 years.

The third trend A.M. Best identified involved the rate of premium growth insurers experienced before their insolvencies. Companies that had unusual premium growth within three years of their insolvencies accounted for 81 percent of all insolvencies. A.M. Best defines unusual premium growth as annual premium growth outside of industry norms of 5 percent to 25 percent. Of our

sample of 10 insolvent property and casualty insurers, 8 (80 percent) had experienced unusual premium growth within three years of their insolvencies.

The fourth trend A.M. Best identified involved the types of insurance lines insurers wrote before their insolvencies. According to A.M. Best, insolvencies occurring in the 1980s were dominated by companies primarily underwriting commercial rather than personal lines of business. Commercial lines are those types of insurance written for businesses, organizations, or other commercial establishments. Personal lines include those types of insurance such as automobile and homeowners' insurance designed for individuals or families, rather than insurance tailored for businesses or organizations. Of our sample of 10 insolvent property and casualty insurers, 7 (70 percent) wrote predominately commercial lines of business.

Glossary

A.M. Best	An agency that provides ratings and financial information on the insurance industry.
Administrative Order	An order the insurance commissioner obtains through an administrative court that directs an insurer to correct or eliminate any condition deemed hazardous to the insurer's policyholders, creditors, or the public.
Affiliate	An entity that controls or is controlled by another entity.
Affiliate Transactions	Transactions occurring between an insurer and its parent company, subsidiary, or affiliate.
Agents' Balance	An account an insurer establishes to recognize amounts its agents owe to the company for premiums collected on the insurer's behalf.
Alien Insurer	An insurer incorporated in another country.
Annuity	An insurance product investment for which a person receives fixed payments over a set period of time.

Association or Multistate Examinations	Multistate field examinations organized by the NAIC for the purpose of allowing states other than the domiciliary state the opportunity to participate in examinations of foreign insurers.
Certificate of Authority	A certificate issued to an insurer allowing it to transact the types of insurance business for which the insurer applied in the state that issued the certificate.
Conservation	Under conservation, an insurer experiencing financial or other problems is placed under court-ordered regulatory control. Generally, the purpose of conservation is to conserve company assets and maintain the status quo until the company's status is finally determined.
Direct Premiums	Premiums relating to the business an insurer writes itself, as opposed to premiums for business an agent writes.
Domestic Insurer	An insurer incorporated in California.
Excess of Loss Reinsurance Agreement	An agreement with another insurance company whereby reported losses beyond an agreed percentage of premium or a specified dollar amount are reimbursed by the reinsurer.
Field Examination	An on-site examination of an insurance company conducted by one or more state regulators.
Foreign Insurer	An insurer incorporated in another state.

Guarantee Association — California established the California Insurance Guarantee Association and the California Life Insurance Guarantee Association for the purpose of paying the covered claims of member property and casualty and life insurers who become insolvent.

Impaired Insurer — An insurer deemed by the insurance commissioner to be potentially unable to fulfill its contractual obligations or an insurer placed under an order of rehabilitation or conservation by a court.

Insolvency — A financial condition in which an insurer is unable to pay claims as they fall due in the normal course of business.

Insurance Regulatory Information System — Analyses performed by the National Association of Insurance Commissioners and used to prioritize insurers for further state regulatory review.

Junk Bonds — Are high-yield non-investment grade bonds according to the grades established by Standard & Poor's, which rates bonds according to their investment worth. The "non-investment" grade falls below the four highest grades Standard & Poor's uses.

Liquidation — A process in which an insolvent company's assets are converted to cash and applied toward its outstanding debt.

Loss Reserves — Funds insurers hold to pay for present and future losses.

Managing General Agent — An individual who manages all or part of the insurance business for an insurer, underwrites premiums, and adjusts or pays claims.

Mandatory Securities Valuation Reserves	A reserve set up by an insurer to anticipate charges to its surplus due to losses from bond and equity securities investments.
Market Conduct Examination	An examination to evaluate an insurer's compliance with requirements in the California Insurance Code regarding selling, advertising, underwriting, rating, and claims servicing.
Monthly Reporting Company	A company required to file financial statements with the department each month.
NAIC	The National Association of Insurance Commissions, which is a voluntary organization of the chief insurance regulatory officials of the 50 States, the District of Columbia, and four United States' territories.
NAIC Financial Ratios	Financial ratios calculated by the NAIC for each participating insurance company through its Insurance Regulatory Information System database. These ratios serve as preliminary tests of the company's financial condition. They measure solvency, liquidity, profitability, and other aspects of insurance companies' operations.
Net Premiums Written	The balance of direct premiums written and assumed reinsurance premiums minus reinsurance premiums ceded to other insurers. An insurer's net premiums constitute a measure of its business volume.
Nonadmitted or Nonauthorized Insurer	An insurer not entitled to conduct business in California.

Premiums — The money an insurer collects for the insurance policies it issues.

Privately Placed Security — A security that is exempt from registration with the Securities and Exchange Commission and is known as a "restricted security" because it cannot be sold to the public in the usual way by a brokerage transaction.

Publicly Traded Security — A security that has been registered with the Securities and Exchange Commission and offered to the public by a securities underwriting dealer.

Questionable Investment Practices — Imprudent investments insurers make that do not provide sufficient protection to policyholders. Imprudent investment practices create a hazard to an insurer's solvency when investment losses, whether realized or unrealized, jeopardize the insurer's ability to pay policyholders' claims when due. An excessive investment in junk bonds is an example of a questionable investment practice.

Realized Loss — The difference between the net proceeds from the sale of a marketable security and its cost.

Receivership — A court-ordered appointment of the commissioner to administer an insurer's business affairs pending litigation.

Rehabilitation — A process in which steps are taken to resolve the cause and condition underlying a company's problems so that it can be returned to normal operations.

Reinsurance	Reinsurance is a form of insurance for an insurance company. Under a reinsurance contract, the primary insurer transfers or "cedes" to another insurer (the reinsurer) all or part of the financial risk of loss accepted in issuing insurance policies to the public. The reinsurer, for a premium, agrees to indemnify or reimburse the ceding company for all or part of the losses the latter may sustain from claims it receives.
Reinsurance Credit	The amount by which an insurer reduces its estimated liability for losses associated with the business it cedes to a reinsurer.
Reinsurance Intermediary	A broker or manager who performs a variety of activities on behalf of a ceding insurer in the case of a broker, or on behalf of a reinsurer in the case of a manager.
Retrocession	A transaction whereby a reinsurer cedes to another reinsurer all or part of the reinsurance it has assumed.
Securities Valuation Office	An office created by the NAIC to provide state regulators and insurers with a source for obtaining uniform prices and quality ratings for insurers' securities holdings. Insurers use these prices and quality ratings in preparing their annual statements, which are filed with state insurance regulators.
Special Reporting Company	A company required to provide periodic reports or correspondence to the department.
Statutory Insolvency	A financial condition in which the minimum capital and surplus required by the states in which the insurer conducts business is impaired.

Surplus The amount by which the assets of an insurer exceed its liabilities less capital.

Underwriting The process of selecting risks for insurance and determining in what amounts and on what terms the insurer will accept the risks.

Unearned Premium At the expiration of an insurance policy or contract, the entire premium has been earned. At any point before expiration, the insurer is required to establish a pro rata portion of the premium as a liability account to cover the remaining policy term. The insurer's total unearned premium represents the unearned premium liability for all policies in force.

Unrealized Loss The difference between the current market value and the purchase price of a marketable security without regard to its sales price.

Watch Company A company showing signs of having potentially serious problems.

JOHN GARAMENDI
Insurance Commissioner

June 22, 1992

Mr. Kurt R. Sjoberg
Auditor General (Acting)
660 J Street, Suite 300
Sacramento, California 95814

Re: Report by the Office of the Auditor General - The Department of Insurance Needs to Make Significant Improvements in its Regulatory Practices Aimed at Controlling Insurers' Insolvencies

Dear Mr. Sjoberg:

The period covered by your recent audit precedes the term of the current administration of the California Department of Insurance ("CDI") with the exception of our decision to conserve Executive Life Insurance Company on April 11, 1991. We appreciate the opportunity you have afforded us to respond to your Report, and will be pleased to report to you in the future on our progress in implementing not only your recommendations, but the additional measures we describe below which we believe will have a dramatic positive impact on insurer solvency regulation in California.

We generally concur with the findings of the Report as they relate to the actions by this Department on specific companies which were the subject of the audit.

On taking office, I directed my staff to conduct a complete review of the operations of the CDI and to develop immediately a plan to ensure that department personnel, with appropriate resolve from the top, would have the tools and information necessary to act thoughtfully and decisively. As of the date of this letter, I am pleased to note that the CDI has already implemented independently the substance of almost all of the recommendations made in your report. Additionally, the CDI is making significant advances in automating the financial analysis process through the development of the Integrated Data Base ("IDB") and an integral part of the IDB, the Early Warning System ("EWS"). The EWS goes far beyond previous efforts both in the CDI and at the NAIC by capturing all forms of information that may be indicative of possible financial problems at an insurer. Whereas prior early warning systems

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have relied on analysis of filed financial statements (annual and quarterly statutory filings), our EWS gathers, categorizes and grades data of all sorts for real time entry into the IDB. The data is then sorted, and reports on an insurer's early warning indicators can be made on a daily, weekly or even instantaneous basis.

Data input into the system includes the usual financial information which is automatically graded for EWS input. Furthermore, complaint data will also be part of the automatic side of the EWS input. Other types of data that will ultimately be automatically input will include product data available from the rate filing and policy approval bureaus of the department. Free form data will also be graded and input into the EWS. Free form data will include such information as information picked up from sources within the industry, tips that may come in through the hotline and information discovered during field examinations and investigations. For example, our post mortem studies of the insolvency of Mission Insurance Company indicated that a number of sources (insurance agents and insurance company officers) had contacted various people in the department advising of Mission's predatory pricing and underwriting practices. If that information had been gathered, categorized and graded as opposed to being kept only in the minds or files of various individuals in the department, it might very well have given the CDI the basis for examining those practices and intervening early enough to prevent Mission's ultimate insolvency.

As of the date of this letter, the CDI has also secured funding to form a full time Troubled Companies Unit for a one-year trial. The Unit will be responsible for the full time monitoring of those companies identified as being in need of immediate regulatory attention and will also be the core group which supports troubled company teams formed to handle specific troubled companies.

We have now had the opportunity to review the Report and to discuss it with Mr. Douglas Cordiner and Ms. Mary Noble of your staff. Our review of the Report and or comments primarily focused on Chapter 1, The Department of Insurance Did Not Always Take Prompt And Decisive Action After It Discovered Problems Leading To Insurers' Insolvencies. Minor issues relating to factual inaccuracies and misconceptions created by the tone or semantics of certain statements of conclusion in the chapter have been discussed with Mr. Cordiner and Ms. Noble and changes as agreed have been made to the Report.

Comments on specific conclusions in Chapter 1 of the Report follow:

1. **Conclusion:**

Informal discussions ultimately failed to yield appreciable results.

Comment:

We agree with this conclusion with regards to the specific cases audited. However, we do believe that informal discussions leading to negotiated results, when appropriately structured and consistently controlled, can be very useful in certain circumstances.

2. **Conclusion:**

There were numerous instances where "watchlist" companies were not afforded additional monitoring effort.

Comment:

Systems have been developed and are continuing to be refined to assure that priority or "watchlist" companies, once identified, cannot "fall through the cracks", but must be monitored until all indicators of hazard are eliminated.

3. **Conclusion:**

Staff recommendations for special or focused examinations and recommendations for Cease and Desist Orders were not acted upon by CDI management.

Comment:

Changes that have been implemented both organizationally and systemically in the CDI require assigning responsibility and accountability to various managers. Those managers must justify their own actions (and document their justifications) if they do not follow through on staff recommendations.

4. **Conclusion:**

Delay in prompt and effective regulatory action can increase the cost of insolvencies by allowing a company to write new policies during the period after which it has been found to have financial problems and by not forestalling deterioration of its financial condition during the period.

Comment:

We certainly agree with that conclusion. We also believe that the organizational changes and the new systems [both procedural and automated such as the Integrated Data Base] that have been implemented during our term will minimize ineffective regulatory efforts caused by unfocused and, therefore, unsuccessful informal negotiations to resolve financial problems. When informal or non-court sanctioned negotiations appear to become fruitless, this administration firmly believes formal regulatory actions must and will be taken.

In reviewing the recommendations at the end of Chapter 1, we believe almost all of the recommendations have significant merit. As noted above, many of the recommendations have already been implemented during my term of office; and for those recommendations not fully implemented, the systemic or organizational changes necessary to implement them have been made or planned. For example:

1. **Recommendation:**

The CDI should revise its methods of investigating officers, directors and major shareholders...

Comment:

While the CDI has recognized the need to investigate the backgrounds of all new officers and directors of insurers, already licensed as well as seeking licensing in California, we have not previously had sufficient investigators to carry out those investigations. However, during the last two years, we have been able to increase the number of investigators in this area from three to five in order to expand our investigatory

resources to monitor officers and directors of insurers already licensed in California.

2. **Recommendation:**

Develop clear criteria for each examiner to use in performing analyses of financial statements and require management to justify and document those instances when examiners' recommendations are not taken.

Comment:

Both the revised Standard Procedures Manuals and the financial analysis programs in the CDI's IDB reflect the implementation of this recommendation.

3. **Recommendation:**

To improve regulatory practices aimed at improper affiliated transactions,the department should request legislation authorizing civil penalties for violations of the Holding Company Act.

Comment:

The CDI has already begun assessing civil penalties for non-compliance with the filing and prior approval requirements of the Holding Company Act pursuant to Insurance Code Section 924. Although that particular code section has been in effect for a number of years, only within the last year have we interpreted its provisions relating to late filing penalties to cover Holding Company Act filing violations. Since Section 924 does not require the Commissioner to hold a hearing in order to assess penalties, we believe that section is preferable to the civil penalties section of the NAIC Model Holding Company Act, which does require a hearing and also limits maximum penalties.

4. **Recommendation:**

To improve regulatory practices, the department should require actuaries to test the reliability of insurers' data as part of their loss reserve certifications.

Comment:

We most certainly agree with this recommendation; however, we have had a difficult time convincing actuaries and the insurance industry of the need for including auditing of source data as part of the loss reserve certification process. Currently, in an attempt to provide uniform standards for loss reserve certifications, the NAIC has included such standards in the instructions for the completion of insurers' annual statements. An attempt was made last year at the NAIC to expand the scope of property/casualty loss reserve certifications to include a statement that underlying data had been audited or verified. That attempt was defeated despite strong support from this department.

Sincerely,

JOHN GARAMENDI
Insurance Commissioner

California Insurance Guarantee Association
P. O. Box 70069
Los Angeles, California 90070

June 17, 1992

Mary P. Noble
Deputy Auditor General
660 J Street, Suite 300
Sacramento, CA 95814

Dear Ms. Noble:

Thank you for letting me review the report entitled "The Department of Insurance Needs to Make Significant Improvements in Its Regulatory Practices Aimed at Controlling Insurers' Insolvencies."

It appears that the report attempted to explain CIGA'S operation through paraphrasing the California Insurance Code which, in my opinion, has created inconsistencies and statements, although minor, that are not entirely correct. I understand that you have made changes in line with our recommendation which would seem to alleviate these inconsistencies.

When your report is finalized, I would appreciate receiving a copy.

Thanks again for your interest.

Sincerely,

John W. Gates
Executive Director

JWG:im

cc: Kurt R. Sjoberg
Auditor General (acting)

cc: Members of the Legislature
Office of the Governor
Office of the Lieutenant Governor
State Controller
Legislative Analyst
Assembly Office of Research
Senate Office of Research
Assembly Majority/Minority Consultants
Senate Majority/Minority Consultants
Capitol Press Corps